

**NATIONAL CAPITAL CONSORTIUM PSYCHIATRY RESIDENCY  
HANDBOOK AND MANUAL**

**April 2003**

**TABLE OF CONTENTS**

NCC Training Agreement.....	3
Background Information/Combined Training .....	6
Clinical Sites .....	6
Application, Selection, and Appointment.....	8
Mission/Philosophy of the Program .....	9
Sponsoring Institution.....	11
Internal Administration.....	12
Policy Committee.....	13
Department Chairs .....	13
Graduation Requirements .....	13
Resident Evaluation .....	14
Summary of Chains of Authority.....	15
Job Descriptions and Supervisory Policy .....	16
Competencies by Graduate Year .....	24
General Psychiatry Rotations.....	28
Didactic Course Work.....	29
Clinical Services .....	47
Military Evaluation .....	62
Due Process.....	62
Faculty and Program Evaluation.....	63

Patient Log Books.....	64
Resident Duty Hours.....	64
Call Policy.....	66
Outside Activities .....	71
Financial Compensation .....	72
Liability Coverage .....	72
Leave.....	72
Essentials of Accredited Residencies in Graduate Medical Education .....	76
Program Requirements for Residency Training in Psychiatry .....	81

I certify that I received that I received a copy of the Residency Handbook and Manual  
on \_\_\_\_\_

---

Name / Rank / Service

Signature

This copy of the training agreement is provided for your convenience. The signed copy remains in the graduate medical education office.

## **NCC GRADUATE MEDICAL EDUCATION TRAINING AGREEMENT**

**PURPOSE:** This document informs residents of the terms and conditions of their appointment to their educational program. The Consortium will monitor the implementation of these terms and conditions by Program Directors.

**AGREEMENT:** I have accepted an appointment as a resident in an education program sponsored by the National Capital Consortium (NCC). The following are the terms and conditions of my appointment.

1. The following terms and conditions are governed by a separate agreement that I made with the Uniformed Service of which I am a member, at the time I accepted appointment as a member of that Service, and before I was appointed to my education program. **I agree to complete Part III USMLE or Part III NBOME during PGY-1 (internship year).** These terms and conditions are not affected by my educational program unless modification is necessary in order to comply with the requirements of the ACGME, the RRC that accredits my program, or the Board that certifies physicians in the specialty for which I am training:

- a) My financial support, as described by Military Pay and Allowances Manual, Sections 10501 through 10536 and supplemented from time-to-time by the Act of Congress.
- b) Vacation policies, as described in the Consortium Administrative Handbook.  
<http://www.usuhs.mil/gme/NCChandbook.htm>
- c) Professional liability insurance, as described in 10 USC 1089.
- d) Disability insurance and other hospital and health insurance, including benefits for myself and my family.
- e) Professional, parental, and sick-leave benefits.
- f) Conditions under which living quarters, meals, and laundry or their equivalents are to be provided.
- g) Provision of counseling, medical, psychological, and other support services.
- h) Grievance procedures, including those covering gender or other forms of harassment.

2. The following terms and conditions are governed by a separate agreement that I made with the Uniformed Service of which I am a member, at the time I applied to my educational program, and before I was appointed to my educational program. Some of these terms and conditions are recorded in military or USPHS orders issued to me when I was assigned to my educational program. These terms and conditions are not affected by my education program unless modification is necessary in order to comply with the requirements of the ACGME, the RRC that accredits my program, or the Board that certifies physicians in the specialty for which I am training.

- a) Duration of appointment and conditions for reappointment.
- b) Service obligation on completion of my educational program.

3. My responsibilities include the following:

- a) To inform myself of the Program Requirements for my education program, as published by the ACGME, and to work with the faculty of my program to achieve substantial compliance with these Program Requirements.
- b) To inform myself of the Due Process procedures of the Consortium, as published in the Consortium Administrative Handbook, and to adhere to these procedures.
- c) To inform myself of established grievance procedures, as published in the Consortium Administrative Handbook including use of military chain of command.

- d) To develop a personal program of learning to foster continued professional growth with guidance from my teaching staff.
- e) To participate in safe, effective, and compassionate patient care, under supervision, commensurate with my level of advancement and responsibility.
- f) To participate fully in the education and scholarly activities of my educational program, and as required, assume responsibility for teaching and supervising other residents and students.
- g) To participate as appropriate in the institutional programs and medical staff activities of the medical treatment facilities in which I work, including activities relating to patient care review, quality assurance, and risk management, including reviews of complications and deaths, and including performance improvement programs.
- h) To serve on institutional committees and councils whose actions affect my education and/or patient care.
- i) To adhere to established practices, procedures, and policies of the medical treatment facilities in which I work.
- j) To inform myself of ethical, socioeconomic, medical/legal, and cost containment issues in medical practice, and to provide patient care in an ethical, medico-legally sound, and cost-effective manner.
- k) To participate in scholarly activity, in collaboration with faculty and my peers. With a view to success in scholarly activity, I shall inform myself concerning research design, the use of statistics, and critical review of the medical literature.
- l) To participate in internal reviews of my educational program, as described in the Consortium Administrative Handbook and to work toward correction of deficiencies identified in internal reviews.
- m) To submit to my Program Director, at least annually, a confidential written evaluation of the faculty and of the educational experiences.
- n) To comply fully with the policies and procedures set by the Uniformed Service of which I am a member to manage physician impairment and substance abuse.

**4. I agree to complete Part III USMLE, or COMLEX, during PGY-1 (internship year), and to obtain a valid unrestricted state medical license by the end of my second year after graduation from medical or osteopathic school. Failure to do so will be reason for adverse personnel actions in accordance with the policies of my Uniformed Service. These may include probation, loss of special pays and benefits reclassification, and/or involuntary separation. Exceptions are granted only for those applying for a license in a state that requires two full years of training prior to issuance. Exceptions are not automatic but must be requested through the Uniformed Service of which I am a member.**

5. I understand that advancement from PGY-1 is based on selection for PGY-2 and satisfactory performance. Failure of continued satisfactory performance after selection for PGY-2 training, but prior to entry, may result in withdrawal of the selection. Advancement to PGY-2 and subsequent years of training is also contingent on compliance with administrative requirements of the NCC and my parent service, if applicable. If I am an Army trainee I must remain in compliance with AR 350-15, AR 600-9 and the "Training Agreement for Army Graduate Professional Education," which prescribes that, **"active duty Army residents must meet service specific height/weight standards and physical fitness requirements to qualify for advancement and graduation from residency."**

6. My responsibilities during my educational program are further defined by Program Information Forms submitted at the time accreditation for my program was requested from the relevant RRC, by Memoranda of Agreement and Understanding between Sponsoring and Participating Institutions involved in my program, and by the policies and procedures of the Medical Treatment Facilities in Clinical Departments in which I may be working from time-to-time. My educational program may be terminated under the following conditions:

- a) If I do not maintain an acceptable level of performance and/or clinical competence. Termination of my education program under these conditions is subject to the Due Process Procedures of the Consortium.
  - b) If I fail due course selection for promotion to the next higher officer grade on two successive occasions. Termination of my educational program under these conditions is at the option of the Uniformed Service of which I am a member, and is not subject to the Due Process Procedures of the Consortium.
  - c) If I am discharged from military service for disciplinary or administrative reasons. Termination of my education program under these conditions is not subject to the Due Process Procedures of the Consortium.
7. I am not allowed to engage in professional activities outside my educational program.
8. Absences from training are generally limited to vacation or medical or convalescent leave. If such absences exceed the time permitted by the RRC or certifying board of the specialty in which I am training I understand that my training may be extended or terminated if extension is not possible.
9. The grievance procedures available to me are those of the military chain of command, procedures prescribed by the military service to which I belong for specific problems such as sexual harassment, and the procedures described in the Consortium Administrative Handbook.
10. Should my residency be closed or reduced in size, my assignment and continued training will be determined by a separate agreement between myself and the Uniformed Service of which I am a member.

**Authorization to release information.**

I understand that as a result of my status as a medical provider the Department of Defense and its instrumentality's, including but not limited to the National Capital Consortium and its successors in interest, will from time to time over the course of my medical career be asked to provide personal information for purposes of determining my professional standing. These requests will include government regulatory agencies, professional boards and organizations as well accrediting organizations such as the Accreditation Council for Graduate Medical Education, American Medical Association, American Association of Medical Colleges, and the American Osteopathic Association. I further understand that these requests will occur during and after my service with the United States Government. In executing this release I hereby authorize the Department of Defense and its instrumentality's, to release personal information about me, including but not limited to name, duty address, duty phone number, duty email address, social security number, date of birth, DEA number, and state license information. I understand that this information may be provided to entities such as those listed above when the Department of Defense and its instrumentality's deem that they have a reasonable need to know the information. I further understand that I can rescind this authorization, but that such rescission **MUST BE IN WRITING and directed to the NATIONAL CAPITAL CONSORTIUM** or its successor(s) in interest. This release will remain in effect until rescinded in writing. I acknowledge that I understand and have been provided a copy of this release.

## **Background Information on the Program**

This Handbook will provide you with information about the National Capital Military Psychiatry Residency Program. Four military medical institutions with traditions of excellence in graduate medical education have joined forces to form an integrated psychiatry residency program. Residents from these institutions consistently score among the highest in the nation on standard training examinations. A large number of graduates have gone on to distinguish themselves as national and world leaders in psychiatry. The Walter Reed Army Medical Center (WRAMC) and the National Naval Medical Center (NNMC) psychiatric training programs were in existence for approximately fifty years before the decision was made to integrate the National Capital programs. At the time of the integration the decision was made to include Malcolm Grow U.S. Air Force Medical Center (MGMC), and the Uniformed Services University of the Health Sciences (USUHS). USUHS serves as the sponsoring institution for graduate medical education. Training in the treatment of patients with chronic mental illness is accomplished through a memorandum of understanding with a fifth institution, the Northern Virginia Mental Health Institute (NVMHI).

The National Capital Military Psychiatry Residency is a four-year program designed to prepare uniformed services residents for the practice of general psychiatry in military and community settings. The program's mission is to train physicians to become effective psychiatrists in the variety of future roles they will fill, from military medical operations to multi-disciplinary mental health settings. The program has more than fifty full-time faculty members, nationally known leaders in a number of areas of psychiatry, including forensic psychiatry, psychopharmacology, psychoanalysis, neuropsychiatry, child and adolescent psychiatry, consultation-liaison psychiatry, geriatric psychiatry and military psychiatry. Applicants from the Army, Navy, Air Force, and Public Health Service may apply to this residency in the same manner as to any other military GME program, by designating the participating institution of his or her service on the military GME application form.

**Combined Training Programs:** The program also offers combined residency training opportunities. There is a five-year combined psychiatry-internal medicine training program at WRAMC and a five-year combined psychiatry-family practice training program at WRAMC and MGMC. Graduates of these combined programs complete requirements necessary for graduation from both residencies and for board certification both in general psychiatry and in internal medicine or family practice. Clinical rotations for the combined programs are outlined later in this manual. Residents who enter into combined training programs and later decide to pursue categorical psychiatry training must obtain permission from their parent service to do so. This option is not guaranteed and residents may be forced to continue training in another program or to enter into a general medical officer position and reapply for residency training at a later date. In the event that residents change from combined to categorical training, the accreditation bodies will be notified to determine how much combined training can be counted for the purpose of eligibility for board certification.

**The Clinical Sites:** Walter Reed Army Medical Center is the flagship medical center of the U.S. Army and has a rich tradition of excellence and leadership in military medicine and graduate medical education. This training center is included because it provides unique clinical opportunities for psychiatric inpatient, partial hospitalization, and consultation liaison rotations. WRAMC serves as a tertiary referral center for service members around the world. It's inpatient psychiatric service admits 900 – 1,000 patients per year and sees a unique patient population including patients with first break episodes of psychotic illness. WRAMC has one of the world's largest institutes of military medical research, the Walter Reed Army Institute of Research. The partial hospitalization service provides an experience with patients with illness and demographic characteristics similar to the inpatient service, but without the need for 24 hour per day care. The consultation liaison service provides service to all other medical services within the hospital,

including a number of specialty clinics with patients with unique psychiatric problems. Rotation on this service during the senior year also provides a geriatric experience with patient with cognitive problems and patients seen in a large nursing home setting. Army residents will spend a majority of their internship year at WRAMC rotating on psychiatry, medicine, surgical, pediatric, and OB/GYN services. WRAMC also provides child and adolescent outpatient training during the third year of training and an outpatient adult behavioral health clinic experience for some of the third year residents.

The National Naval Medical Center serves as "The President's Hospital." This flagship Navy medical center is across the street from the National Institutes of Health and shares a campus with the Uniformed Services University of the Health Sciences. NNMC provides a one-month experience on the adolescent inpatient service. It also has a well-integrated, multi-disciplinary behavioral health service for training in outpatient adult psychiatry. Navy residents will spend a majority of their internship year at NNMC rotating on psychiatry, medicine, surgical, pediatric, and OB/GYN services.

Malcolm Grow U.S. Air Force Medical Center is on Andrews Air Force Base, an active military base that serves the President and members of Congress. The focus of psychiatric training at MGMC is in the subspecialty of addictions. Air Force residents in combined psychiatry/family practice training will spend approximately half of their time in training at MGMC in the family practice residency and will also accomplish their outpatient adult and child and adolescent rotations at this site.

The Uniformed Services University of the Health Sciences is the uniformed service's own medical school and is a center for military psychiatry research. USUHS medical students also rotate in the residency's participating institutions during their third and fourth years of medical school.

Northern Virginia Mental Health Institute is part of the Commonwealth of Virginia's system of mental health services. Residents gain experience with patients with chronic mental illness by rotating on several units of this 120 bed hospital. Residents gain knowledge and experience in managing patients with chronic and severe psychiatric conditions and develop an understanding of the community psychiatry system and the transition between various levels of care.

### **Program Overview and Structure**

This Handbook begins with an overview of the residency program and its structure, followed by detailed descriptions of clinical rotations, courses, and seminars for each of the four training years. It concludes with a description of program policies, procedures, and opportunities to enrich the residency training experience. The Handbook is intended for residents and faculty, as well as for medical students interested in knowing more about the program. The Residency Policy Committee, department chairs, and all faculty members encourage you to ask questions and share your ideas with us. This residency program has the best of both worlds: decades of tradition and history that emerge from the participating institutions as well as a sense of innovation and an eagerness to try new things. There are almost limitless opportunities to learn and thrive in the National Capital Military Psychiatry Residency Program. The Washington DC area has five other outstanding academic medical centers: the Armed Forces Institute of Pathology, the National Institutes of Health, the National Library of Medicine, and the Walter Reed Army Institute of Research.

Required rotations are scheduled so that travel is minimized and individual faculty mentoring is emphasized. Training sites must meet stringent criteria with regard to travel time, faculty supervision, and continuity of experience. Training at multiple sites is necessary due to the unique clinical experiences available at the separate sites.

## **APPLICATION, SELECTION AND APPOINTMENT**

### **GENERAL POLICIES:**

Applicants to the NCA Military Psychiatry Residency must be on active duty or previously selected for active duty in one of the uniformed services of the United States. Applicants must be U.S. citizens and have a command of the English language sufficient to facilitate accurate and unhampered communication with patients and teachers.

### **APPLICATION PROCEDURES:**

**PGY-1 APPLICANTS:** The program participates in the ERAS application system. Applicants must also submit their applications and credentials to the Office of Graduate Medical Education in their respective military services. HPSP and USUHS students should receive standard application materials automatically from their respective military services. Each medical center in the program also has a GME Office, which can help provide necessary application materials if not received and answer questions. The residency program office can also help with the application process. Students in the U.S. Public Health Service should contact the program director for more specific information applicable to their application process. If you have any questions about the application procedure, please call the Program Executive Assistant, Ms. Wolford at 202.782.5989.

**APPLICANTS IN ADVANCED STANDING:** Applicants for admission in advanced standing (PGY-II and beyond) follow the same procedures as applicants for PGY-I positions, except that ERAS does not apply. Physicians are appointed for entry to the program at the second postgraduate year level only after: (a) a clinical year of training in an Accreditation Council of Graduate Medical Education (ACGME) accredited program in internal medicine, family practice, or pediatrics, (b) an ACGME accredited transitional year program, or (c) one year of an ACGME accredited residency in a clinical specialty requiring comprehensive and continuous patient care.

### **INTERVIEWS AND ELECTIVE ROTATIONS:**

Applicants are encouraged to arrange interviews with members of the selection committee. These interviews may be conducted by telephone when a potential applicant cannot physically be present. Failure to interview would be one factor in merit order ranking of applicants. If possible, medical students are also encouraged to arrange elective rotations at one of the participating institutions. These rotations provide a chance to meet the faculty and become acquainted with the residency program.

### **SELECTION PROCEDURES:**

Members of the faculty and resident staff of the NCA Psychiatry Residency program interview applicants in person, although in certain cases interviews can be arranged by telephone or at other sites. In most instances the Program Director will interview all applicants. The Residency Policy Committee of the NCA Psychiatry Residency Program examines the applications, credentials, curriculum vitae and applicant interview reports. Department chairs and service chief representatives may supplement the Committee for the selection process. The Committee ranks the applicants in order of preference. The rank order is determined by many factors, including interview results, the applicant essay, medical school academic performance, and commitment to the philosophy and goals of the program. Final selection decisions are made at the Graduate Medical Education Selection Board held in late autumn of each year.

in consultation with program directors from other military GME institutions offering psychiatry residency training.

When appointments are made at or beyond the PGY-II level, credentials and past training are documented to ascertain that the individual has met essential requirements for the first postgraduate year. Applicants for transfer from other psychiatric training programs must provide written documentation from the previous training program(s) as to past clinical training, performance and professional integrity. This documentation is always made a part of the resident's permanent training record. We ensure that all transferring residents will have progressive levels of clinical responsibility, avoid redundancy of clinical and didactic training, and meet our program criteria for the given PGY year level of appointment as well as ultimately the criteria for graduation. The Program reserves the right to repeat specific elements of PGY-I training if lack of current knowledge or skill becomes apparent through in-service examinations or clinical performance.

### **APPOINTMENT:**

Upon selection and admittance to the residency, residents receive appointment as a captain in the Army and Air Force or as a lieutenant in the Navy. Individuals with prior military experience may be commissioned at a higher rank in accordance with the procedures of their parent service. Residents report to their medical centers of primary assignment in late June for orientation to the residency program and to the medical centers in the area. Officers new to the military receive basic officer instruction prior to beginning residency training.

### **MISSION:**

Train military physicians to become effective psychiatrists in the variety of future roles they will fill, including military medical settings, multi-disciplinary mental health settings, and primary care and other medical-surgical settings.

### **PHILOSOPHY:**

**The following elements comprise the program's training philosophy:**

***1. Military psychiatrists must be flexible and adaptable.*** In the emerging health care environment, all physicians are learning new ways and means of practicing medicine. Psychiatry is no exception. Whether it is new roles or new settings, psychiatrists must be fast on their feet and confidently accept new challenges as opportunities, not as threats. Being flexible and adaptable is particularly important in military psychiatry, where a psychiatrist may suddenly find him or herself in unfamiliar surroundings and asked to function in unaccustomed roles. For example, a psychiatrist deployed on an operational military mission or a military mission other than war (e.g., peacekeeping, natural disasters, bombings) may act as a primary physician many days or weeks before seeing patients whose signs and symptoms are predominantly psychiatric. Both a firm medical knowledge base and mental flexibility/adaptability are important to succeeding in such unique environments. To teach this way of thinking and practicing, the residency challenges residents to use lessons learned in previous rotations to adapt to new ways of operating. Each year of the residency increases the variability of experiences residents are exposed to. Experienced military psychiatrists help residents learn to adapt to new settings and roles by mentoring and example.

**2. *Military Psychiatry is a specialized area of psychiatric and medical practice requiring unique skills and knowledge.*** Psychiatrists in the military play active operational and medical support roles. The program faculty believes that caring for families and for service-members during peacetime is an essential component of medical readiness for war and military operations other than war. A large proportion of the program's teaching emphasizes the psychiatrist's role in maintaining operational readiness.

**3. *Psychiatrists in the military must increasingly have a tri-service base of knowledge and experience to function effectively.*** Military physicians, including psychiatrists, increasingly function in tri-service military environments. Residents in this program are exposed to cultures, traditions, and practice contexts in all three military services.

**4. *Psychiatrists must be able to function confidently and effectively in a number of roles and settings.*** Psychiatrists in the 21st Century will be called upon to practice in many different settings, including primary care clinics, tertiary care medical centers, community hospitals, multi-specialty physician groups, multi-disciplinary mental health groups, and managed care environments. They will also fill a number of roles, including consultant, principal physician, medical director, team leader, organizational advisor, expert witness, administrator, and teacher. Graduates of this program must be able to confidently fill each role and practice comfortably in each setting.

**5. *Psychiatrists are "Principal Care" physicians.*** Psychiatrists are clearly specialists with deep knowledge in one specific area of medicine. Psychiatrists must retain and utilize broad medical knowledge in their practices. Psychiatrists often find themselves being the patient's principal physician. Patients may also access psychiatric care directly. Psychiatrists must therefore retain skills in medical evaluation, differential diagnosis, and treatment. Differential diagnosis of psychiatric signs and symptoms always includes a medical differential diagnosis. These diagnostic evaluations are often quite complex and require a solid base of medical knowledge beyond the scope required to narrowly manage primary psychiatric illness. Psychiatric treatments can have significant medical and physiological side effects, which require the full attention only a physician can bring to bear in order to promote successful treatment outcomes. The National Capital Military Psychiatry Residency Program has constructed a curriculum that assures that basic medical skills are maintained and expanded throughout the entire four years of the program.

**6. *Psychotherapy is indispensable to the practice of Psychiatry.*** Psychiatrists must be experts in psychotherapy. The principles absorbed in learning the various forms of psychotherapy form a mainstay of psychiatrist identity and skill. The comprehensive approach to a patient, that frequently only a psychiatrist can offer, depends on principles of individual and group behavior that psychotherapy instruction offers. In addition, psychiatrists frequently supervise other medical and mental health professionals who are performing psychotherapy with patients under the direct responsibility of the supervising psychiatrist. The need to understand whether supervised colleagues perform effective psychotherapy requires an even more complete knowledge and experience base in psychotherapy than doing psychotherapy oneself. The residency emphasizes psychotherapy training to a degree rarely found in psychiatry residency programs today. The faculty includes expert teachers in a wide variety of therapies, including family, group, long-term and short-term psychodynamic, cognitive, and behavioral. The program coordinates individual psychotherapy supervision by experienced military and civilian Washington DC area psychotherapy experts.

**7. *Psychiatrists are most effective when practicing the Biopsychosocial Model.*** Psychiatrists are the only medical professionals and the only mental health professionals comprehensively trained in biological/medical, psychological, and social/cultural aspects of a patient's presentation. Accordingly,

the program has constructed clinical rotations and a careful mix of courses and seminars that continually integrate biological, medical, psychological, social, and cultural bases of knowledge.

**8. *Psychiatrists must be prevention-oriented.*** A dramatic reality of military medicine is that prevention wins wars. Similarly, a preventive orientation by a psychiatrist is necessary to be clinically and economically effective. The residency emphasizes primary, secondary, and tertiary prevention approaches to psychiatric practice. Whether it is primary prevention efforts with community military commands or secondary and tertiary prevention efforts in clinics and hospitals, residents receive clinical supervision and course lectures designed to illustrate the value of conceptualizing a psychiatric practice as a preventive specialty. Even with clinical experiences among chronically mentally ill, residents are taught to identify areas for effective preventive interventions.

**9. *Psychiatrists must be excellent teachers.*** Because psychiatrists have the unique perspective of being both a physician and mental health professional, they are called upon to teach and consult in a variety of community and professional settings. For example, psychiatrists in the military consult with commands on managing disasters and military unit dysfunction. They supervise and work with non-physician mental health professionals, who often ask for guidance and instruction in biopsychosocial aspects of their work. Psychiatrists teach other physicians to manage uncomplicated psychiatric disorders in their practices. They teach patients and their families about their conditions and treatments. Psychiatrists teach medical students, who may not have another chance to develop a broad identity as a physician who uses a biopsychosocial approach to patient care instead of a narrow physiological focus. Residents in this program are given mentored experiences in teaching from the earliest days of the residency. Medical students from USUHS rotate on units where they are supervised by psychiatry residents. Residents are given hands-on experience in teaching military leaders and primary care physicians during the four years of the residency.

**10. *Psychiatry as a discipline must have a firm academic foundation.*** The National Capital Military Psychiatry Residency Program has integrated into its educational program continual exposure to sentinel research findings to date as well as to new research that will occur during the four years of the residency. Residents are taught to critically evaluate and understand the medical literature as it relates to diagnosis and treatment of psychiatric conditions. Residents receive mentoring in their own research project, including conceptualization, design, implementation, and interpretation. Awards and opportunities to present research findings at scientific meetings are used to stimulate interest in research and other academic pursuits among residents. Post-graduate fellowships are offered at participating institutions for residents who want to deepen and specialize their academic foundation.

## **SPONSORING INSTITUTION**

The *National Capital Military Psychiatry Residency Program* is one of a number of integrated graduate medical programs in the National Capital Area. These programs are part of the *National Capital Consortium for Graduate Medical Education*. The Consortium provides overall policy direction for the integrated GME programs (e.g., due process and appeals) as well as a structure for cooperative training among area military GME programs. A copy of the National Capital Consortium Handbook is available in the education office (Room 2061 Building 6 – Borden Pavilion – Walter Reed Army Medical Center) and can be viewed and printed from site <http://www.usuhs/mil/gme/NCC.htm>.

## **INTERNAL ADMINISTRATION**

The NCA Military Psychiatry Residency Program has an executive *Policy Committee*. The Policy Committee formulates policy for the residency program and monitors overall resident progress. The Policy Committee designs rotation objectives, coordinates courses, and plans residency review activities. The Policy Committee is comprised of the program director, on-site training directors of the four participating institutions, a senior faculty consultant, PG year committee representatives, psychiatric fellowship program directors, and the president of the Council of Psychiatric Residents.

There is a training committee for each level of training. Each PG year committee is chaired by a faculty coordinator and includes faculty members from each service where residents rotate that year, as well as a resident. The PG year committees report their activities to the Policy Committee.

The Program Director is full-time and includes the following responsibilities: resident appointments and assignments, administering and directing educational activities, coordinating training in each geographically separate institution, and providing written information to residents and applicants regarding financial compensation, liability coverage, and program policies. The program director also chairs the program's policy committee and reports on residency issues and problems to participating institution department chairmen for their review and approval. The program director reports to the executive officer of the NCC Graduate Medical Education Committee and coordinates with participating institution department chairmen via the USUHS Advisory Board. The participating institutions' on-site training directors are appointed by the NCC with concurrence of the department chairs of those institutions.

The Council of Psychiatric Residents (CPR) serves as the self-governance body for the residents. The CPR serves as a center for discussion of administrative, educational, and interpersonal difficulties encountered by residents in the program. The president of the CPR serves as a chief resident, responsible for administrative representation of all residents in the program on the residency policy committee. This resident will be nominated by vote of the residents but be subject to final approval by the previous academic year's training committee. There are also elected representatives from each of the combined training programs. The residency program will, from time to time, with appointment by participating institution department chairs, form time-limited subcommittees and working groups to provide consultation on important issues needing review or work (e.g., annual retreat planning). Residents are represented on these groups.

Resident records are maintained at a central location and are the responsibility of the Residency Training Committee. Individual clinical rotation evaluations will be coordinated by the Training Year Committee according to standards developed by the Policy Committee.

### **NATIONAL CAPITAL MILITARY PSYCHIATRY RESIDENCY POLICY COMMITTEE**

Program Director (Chair);	Thomas A. Grieger, M.D., CAPT, MC, USN
Senior Faculty Consultant	Maria Esposito, M.D., COL, MC, USA (RET)
Assistant Training Director / Curriculum Committee Chairman	Douglas Waldrep, M.D., LTC, MC, USA
Site Associate Training Director, WRAMC	Douglas Waldrep, M.D., LTC, MC, USAF
Site Associate Training Director, NNMC	John Lyazczarz, M.D., LCDR, MC, USN
Site Associate Training Director, MGMC	James Cockerill, M.D., LtCol, MC, USAF
Site Associate Director, NVMHI	Kerry Shrewsbury, M.D.
PGY2 Committee Chair	Theodore Nam, M.D., COL, MC, USA
PGY3 Committee Chair	John Lyszczarz, M.D., LCDR, USN
PGY4 Committee Chair	Douglas Waldrep, M.D., LTC, MC, USA
Psychiatry/Family Practice Program Director	Timothy Lacy, M.D., LtCol, MC, USAF
Child/Adolescent Fellowship Director	Nancy Black, M.D., MAJ(P), MC, USA
Forensic Fellowship Director	David Benedek, M.D., MAJ(P), MC, USA
Geriatric Fellowship (interim) Director	Charles Millikan, M.D., LTC, MC, USA

### **PSYCHIATRY DEPARTMENT CHAIRS OF PARTICIPATING INSTITUTIONS:**

Uniformed Services University	Robert Ursano, M.D., Col., MC, USAF (ret)
Walter Reed	Stephen Cozza, M.D., LTC, MC, USA
National Naval Medical Center	Ronald Smith, M.D., CAPT, MC, USN
Malcolm Grow Medical Center	TBD

### **Graduation Requirements:**

In order to graduate from the National Capital Military Psychiatry Residency Program, the resident must demonstrate that he or she possesses sound clinical judgment and a high order of knowledge about the diagnosis, treatment, and prevention of all psychiatric disorders and the common medical and neurological disorders which relate to the practice of psychiatry in the general community and the Armed Services. While residents cannot be expected to achieve in four years the highest possible degree of expertise in all of the diagnostic and treatment procedures used in psychiatry, they must be competent to render effective professional care to patients in all the roles and settings taught by the program. They must have a keen awareness of their own strengths and limitations and of the necessity for continuing their own professional development. Graduates must be documented evidence of continuous ethical behavior, professional behavior, self directed learning, and clinical competence.

Detailed descriptions of Goals and Objectives for each of the four years of training are included in this Handbook and are outlined in the form of Competency checklists. Each resident must substantially fulfill all Goals and Objectives. The progress of each resident will be continually monitored and frequently evaluated. These evaluations will be discussed with the Program Director at regular and frequent intervals, and remedial work or studies will be assigned whenever necessary.

The NCA Military Psychiatry Residency Program is organized to facilitate the fulfillment of Objectives and Criteria for Graduation for those who complete its four years of postgraduate education. Applicants who plan to enter in advanced standing (after the PGY-1 year) may require program modifications to

meet the Objectives and Criteria for Graduation, and should read the subsection entitled "Applicants in Advanced Standing" in the Section *Appointment Process* in this Handbook.

## **RESIDENT EVALUATION**

You will receive frequent evaluations during your residency, and you will be frequently asked to evaluate your curriculum and teachers. Both types of evaluations are a part of an educational continuing quality improvement program that is intended to produce the best possible trainees, and to constantly improve the training program. All clinical training in PGY-2 through PGY-4 includes at least two hours of individual supervision on a weekly basis, in addition to teaching conferences, group meetings and rounds. There are also regularly scheduled and documented evaluative meetings with individual residents to discuss their evaluations and progress in the program. These meetings are held at least semiannually. A summary from these meetings is entered in the training record.

Detailed competencies for each year group are provided on pages that follow. In addition there are detailed evaluation forms for each clinical rotation. In most instances the evaluation must be completed collaboratively with the resident and the supervisor. These evaluation forms will be revised on an ongoing basis to reflect the changing nature of the clinical experiences and specific goals and objectives required by the Psychiatry RRC of the ACGME.

The residency training committee maintains training files on each resident that contain the following: application materials and credentials, all rotations and clinical assignments, all evaluations, documentation that all required clinical experiences have been satisfactorily accomplished, a record of any due process actions, and a statement by the program director, upon graduation, that there is no documented evidence of unethical behavior, unprofessional behavior, or serious question of clinical competence. Residents may receive copies of any evaluations upon their request.

In addition to regular evaluations by your supervisors, there are two formal examinations each year. The PRITE (Psychiatry Resident In-service-Training Examination) is a written examination that allows you to compare your level of knowledge on a variety of subjects with the knowledge of residents throughout the country. Results are used by the Program Residency Training Committee to help plan the program as a whole and the individual development of each resident.

The annual Clinical Competence Examination is modeled on the oral board certification examination for psychiatrists, and consists of an interview of a patient in the presence of one or two senior faculty members or while being videotaped, followed by an oral examination by the faculty members. Your skills in assessment, diagnosis, formulation and treatment planning will be evaluated. When a resident is seen to need additional training in knowledge, skills, or interview style there is a well-defined procedure to be followed to provide that extra help. The process begins with clear definition of areas needing improvement, and continues with a structured plan aimed at providing additional instruction without unduly disrupting training. All residents are encouraged to interview and present their findings in this format on a frequent basis in the course of their routine clinical duties and case supervision.

### Summary of Chains of Authority

Depending on the nature of the matter at hand, there are different sources for answering your questions or resolving a problem. The following table provides guidance. If you have a specific question not answered by the table, please contact the education office.

<b>Clinical Matters (Patient care, record keeping, quality assurance)</b>	<b>Educational Matters (Progression to further training, remediation, probation, etc.)</b>	<b>Administrative/Military Matters (Officer evaluations, leave, travel, military discipline, physical fitness testing)</b>
Department Chair	NCC Graduate Medical Education Committee	Hospital Commander
Service Chief	Policy Committee/Program Director	Director of Clinical Services / Brigade commander
Attending Physician	Site Associate Director	Department Head/Company Commander
Senior Resident (if assigned)	Training Year Group Chairman	Assigned Rater
Junior Resident	Individual Supervisor	
Intern		
Medical Student		

## **Job Description and Supervisory Policy for Residents in the NCC Psychiatry Residency**

### **General limitations in scope of practice:**

PGY1 residents may not perform independent evaluations for admission, perform independent consultation of patients on other clinical services, order restraint of patients, or carry the POD pager at any time.

PGY2 residents may independently evaluate patients for admission, but all inpatients must be directly evaluated by a staff physician within 24 hours.

PGY3 residents may independently evaluate outpatients, but must staff all new evaluations with staff within 48 hours of first visit and for subsequent visits within the guidelines cited below.

PGY4 residents may provide confirmatory evaluation for patients seen by PGY1 and PGY2 residents for outpatients, consultation liaison service patients and, and continuity services patients.

### **PGY1:**

#### **Inpatient:**

1. Evaluate new patients assigned: performing and documenting a history and physical examination or resident accept note for all new patients. All new patients must have a direct evaluation performed by a staff attending physician and documented within 24 hours of admission.
2. Prescribe medication.
3. Perform psychotherapy (individual and group).
4. Assist staff in performance of electro-convulsive therapy
5. Perform command consultation.
6. Document changes in clinical status, diagnosis, prognosis, and treatment changes in progress notes in the frequency specified for the clinical service. Progress note entries will be made at least three times weekly and more frequently when changes occur in the patient's condition, treatment, or prognosis. Confirmation of resident supervision will be documented in progress notes entered by the attending or reflected within resident notes. The attending's or the PGY4/5 resident's signature alone suffices as documentation of supervision of the resident when it corresponds with the progress note. By signing the note the attending/ PGY4/5 resident concurs with the note as written. If there is additional information required or a correction/clarification of the note is required the attending/ PGY4/5 resident will include his own note. The attending may add additional information as required or have the resident add the information as long as the attending/ PGY4/5 resident signs or supervision is documented by the resident in the progress note.
7. Participate in medication rounds and treatment planning
8. Prepare Narrative Summaries and Medical Evaluation Boards. All narrative summaries must be signed by a staff attending physician.
9. Assist with discharge planning.
10. Determine (under staff supervision) patient safety and transfer to alternate levels of care.
11. Provide routine ambulatory medical care (such as wound care and evaluation of medical complaints)
12. Consult other clinical services for specialty evaluation and care
13. Supervise medical students

#### **Restrictions of practice:**

1. May not order physical restraints

2. All new patients must be personally evaluated by PGY2 resident on call and must be personally evaluated by staff within 24 hours of admission
3. May not discharge patient without staff review and approval
4. May not provide independent clinical assessment or recommendations.

### **Partial Hospitalization Service/Continuity Outpatient Services**

1. Evaluate new patients assigned: performing and documenting a history and physical examination or resident accept note for all new patients. The initial intake or the first visit with that patient must be staffed by the attending or the designated chief resident before the patient leaves the clinic. For patients assigned to the Medical Holding Company and walk-ins to WD 53, all patient visits will be staffed by a staff attending physician or senior resident before the patient leaves the clinic
2. Prescribe medication.
3. Perform psychotherapy (individual and group).
4. Assist staff in performance of electro-convulsive therapy
5. Perform command consultation.
6. Document changes in clinical status, diagnosis, prognosis, and treatment changes in progress notes in the frequency specified for the clinical service. For patients assigned to the Partial Hospital, PGY-1 residents will complete at least two notes per week. The first note can be the intake, acceptance note, transfer note or any documentation reflecting assumption of the patient's care. The following notes will be a summary note of the patient's care at a minimum of every three working days. The last note will be the discharge note. Additional notes are required whenever a patient is seen in medication rounds or to document any incident that is an exception to routine care or that changes the patients treatment plan (i.e., medication changes, side effects, diagnosis change, presents as a danger to themselves or others). These additional notes can meet the requirement for the notes described above. Confirmation of resident supervision will be documented in progress notes entered by the attending/PGY4/5 resident or reflected within resident notes. The attending's or the more senior resident's signature alone suffices as documentation of supervision of the resident when it corresponds with the progress note. By signing the note the attending/ PGY4/5 resident concurs with the note as written. If there is additional information required or a correction/clarification of the note is required the attending/chief resident will include his own note . The attending/PGY4/5 resident may add additional information as required or have the resident add the information as long as the attending/ PGY4/5 resident signs or supervision is documented by the resident in the progress note. Each outpatient record must reflect an attending and indicate if the case was discussed with the attending or another attending or more senior resident. All patients seen by residents in their Post-graduate Year One (PGY-1) year must be discussed with an attending/ PGY4/5 resident, with this discussion documented in the patient's record.
7. Participate in medication rounds and treatment planning
8. Prepare Narrative Summaries and Medical Evaluation Boards
9. Assist with discharge planning.
10. Determine (under staff supervision) patient safety and transfer to alternate levels of care.
11. Provide routine ambulatory medical care (such as wound care and evaluation of medical complaints)
12. Consult other clinical services for specialty evaluation and care
13. Supervise medical students

### **Restrictions of practice:**

1. May not order physical restraints

2. All new patients must be staffed by PGY4/5 resident or staff before leaving the unit. For patients assigned to the Medical Hold Clinic, and walk-ins to ward 53; all patients visits will be staffed before the patient leaves the clinic
3. All progress notes must be signed by PGY4 or staff. At a minimum supervision will be documented in the residents note or the note will be co-signed by the senior resident or the attending weekly
4. May not discharge patient without staff or PGY4 review and approval. All discharge summaries must be approved and signed by the chief resident and the attending physician

#### **Consultation Liaison Service:**

1. Evaluate new patients assigned to residents: performing and documenting a history and physical examination or resident accept note for all new patients. A PGY4/5 resident or attending staff must supervise all cases directly or indirectly.
2. Provide consultation recommendations including use of medication, psychotherapy, environmental changes, and nursing practices. A PGY4/5 resident or attending staff must supervise all cases directly or indirectly.
3. Perform psychotherapy (individual and group). A PGY4/5 resident or attending staff must supervise all cases directly or indirectly.
4. Assist staff in performance of electro-convulsive therapy
5. Perform command consultation. A PGY4/5 resident or attending staff must supervise all cases directly or indirectly.
6. Document changes in clinical status, diagnosis, prognosis, and treatment changes in progress notes in the frequency specified for the clinical service. A PGY4/5 resident or attending staff must countersign all notes.
7. Participate in medication rounds and treatment planning
8. Assist with discharge planning.
9. Determine (under staff supervision) patient safety and transfer to alternate levels of care.
10. Provide initial evaluation of patient in the emergency department under PGY4 or staff supervision.
11. Supervise medical students

#### **Restrictions of Practice**

1. May not order physical restraints
2. All new patients must be personally evaluated by PGY4/5 resident or staff before placing findings and recommendations in the official medical record.

While on the inpatient, partial hospitalization, and consultation liaison service, each resident will obtain two hours per week of staff or PGY4/5 supervision (direct or indirect). This may be spread across the course of the work week.

#### **Other Services:**

While officially assigned to other clinical services throughout the hospital (and at MGMC and NNMC), duties and supervision will be according to the policies of the assigned clinical service)

#### **On Call (psychiatry):**

1. Evaluate psychiatric and medical complaints of patients on Ward 54
2. Assist PGY2 in evaluation of patients in the emergency department and hospital consultations
3. Document new evaluations personally performed and obtain PGY2 review and approval (with appropriate comment)

Restrictions of practice:

1. May not order physical restraints
2. All new patients must be personally evaluated by PGY2 resident on call and must be personally evaluated by staff within 24 hours of admission
3. May not carry the hospital psychiatry pager
4. May not perform independent hospital consultations

**PGY2:**

Inpatient, Partial Hospitalization, NVMHI, Addiction and Adolescent Services:

1. Evaluate new patients assigned to residents performing and documenting a history and physical examination or resident accept note for all new patients. All new inpatients must have a direct evaluation performed by a staff attending physician and documented within 24 hours of admission.
2. Prescribe medication.
3. Perform psychotherapy (individual, family, and group).
4. Assist staff in performance of electro-convulsive therapy (adults only at WRAMC)
5. Assess patients requiring restraint and provide restraint orders as appropriate.
6. Perform command consultation.
7. Document changes in clinical status, diagnosis, prognosis, and treatment changes in progress notes in the frequency specified for the clinical service. For inpatients at WRAMC, residents will complete at least three notes per week. For APPHP patients residents will complete at least two notes per week. The first note can be the intake, acceptance note, transfer note or any documentation reflecting assumption of the patient's care. The following notes will be a summary note of the patient's care at a minimum of every three working days and a minimum of three times per week for inpatients. The last note will be the discharge note. Additional notes are required whenever a patient is seen in medication rounds or to document any incident that is an exception to routine care or that changes the patient's treatment plan (i.e., medication changes, side effects, diagnosis change, presents as a danger to themselves or others). These additional notes can meet the requirement for the notes described above. Confirmation of resident supervision will be documented in progress notes entered by the attending / PGY4/5 resident or reflected within resident notes. The attending's / PGY4/5 resident's signature alone suffices as documentation of supervision of the resident when it corresponds with the progress note. By signing the note the attending / PGY4/5 resident concurs with the note as written. If there is additional information required or a correction/clarification of the note is required the attending/ PGY4/5 resident will include his own note. The attending may add additional information as required or have the resident add the information as long as the attending/chief resident signs or supervision is documented by the resident in the progress note.
8. Participate in medication rounds and treatment planning
9. Prepare Narrative Summaries and Medical Evaluation Boards. All narrative summaries must be signed by a staff attending physician
10. Assist with discharge planning.
11. Determine (under staff supervision) patient safety and transfer to alternate levels of care.
12. Provide routine ambulatory medical care (such as wound care and evaluation of medical complaints)
13. Consult other clinical services for specialty evaluation and care
14. Assist in supervision and education of PGY1 residents.
15. Supervise medical students

While on the inpatient, partial hospitalization, NVMHI, adolescent, and addictions services, each resident will obtain two hours per week of staff or PGY4 supervision (direct or indirect). This may be spread across the course of the work week.

**On Call (short call/weekends and emergency psychiatry rotation)**

1. Supervise PGY1 residents in the evaluation of psychiatric and medical complaints of patients on Ward 54
2. Evaluate patients in the emergency department, hospital (and air evacuation) transfers, and hospital consultations
3. Document new evaluations and changes in care
4. Provide and document personal evaluation of all initial evaluations performed by the PGY1 resident
5. Carry the emergency pager and respond to all pages (emergency department, outside physicians, commands, and patient questions)
6. Provide command consultation
7. Assist when requested with transfers and acceptances from other services
8. Assess patients needing restraint and provide restraint orders as appropriate
9. Supervise medical students and PGY1 residents.

**Restrictions of practice:**

1. All discharges or transfers from the units or emergency department must be discussed with the staff on call prior to the discharge.
2. All restraints must be discussed with staff.
3. All hospital consultations must be discussed with staff before the recommendations are entered into the official records.
4. All other admissions must be presented and discussed during morning report the following morning.

**PGY3:**

**Outpatient**

1. Evaluate new patients assigned to residents performing and documenting a history and physical examination or resident accept note for all new patients on the date of first visit. Each new patient must be reviewed by staff within 48 hours of the visit and the record must have documented evidence of staff supervision. All new child and adolescent evaluations will be under direct staff supervision.
2. Prescribe medication.
3. Perform psychotherapy (individual, family, couples and group)
4. Perform command consultation.
5. Conduct security evaluations (under supervision of forensic service faculty or fellow)
6. Perform TDRL evaluations
7. Assist in sanity board examinations (under qualified staff supervision)
8. Document changes in clinical status, diagnosis, prognosis, and treatment changes in progress notes for each clinical visit. All charts must be reviewed by staff every 6 visits or every four months (whichever is sooner)
9. Participate in clinical case conferences
10. Prepare Medical Evaluation Boards
11. Determine (under staff supervision) patient safety and transfer to alternate levels of care. All patients viewed as dangerous must be discussed with staff before they leave the treatment area.
12. Consult other clinical services for specialty evaluation and care
13. Supervise medical students

All residents must obtain two hours of individual faculty general case supervision per week (in addition to specialty supervision for specific psychotherapy techniques)

**On Call (NNMC and MGMC from home):**

1. Evaluate patients in the emergency department, hospital (and air evacuation) transfers, and hospital consultations
2. Document new evaluations and changes in care
3. Personally evaluate all patients admitted to the adolescent unit at NNMC.
4. Carry the on-call pager and respond to all pages (emergency department, outside physicians, commands, and patient questions)
5. Assist when requested with transfers and acceptances from other services
6. Assess patient needing restraint and provide restraint orders as appropriate

All discharges from the units or emergency department or transfers to other hospitals must be discussed with the staff on call prior to the discharge. All restraints must be discussed with staff. All hospital consultations must be discussed with staff before the recommendations are entered into the official records. All other admissions must be presented and discussed during morning report the following morning

**PGY4/5:**

Inpatient, Partial Hospitalization, NVMHI, Addiction and Adolescent Services:

1. Review evaluations performed by PGY1 and PGY2 residents on new patients and ensure that a history and physical examinations or resident accept note are appropriate and present for all new patients.
2. Prescribe medication and supervise prescription by junior residents.
3. Perform psychotherapy and supervise junior resident psychotherapy (individual, family, and group).
4. Assist staff in performance of electro-convulsive therapy (adults only at WRAMC)
5. Assess patients requiring restraint and provide restraint orders as appropriate.
6. Perform command consultation.
7. Review and sign PGY1 and PGY2 documentation of changes in clinical status, diagnosis, prognosis, and treatment changes in progress notes twice weekly for APPHP and three times weekly on the inpatient unit. Confirmation of resident supervision will be documented in progress notes entered by the senior resident or reflected within resident notes. The senior resident's signature alone suffices as documentation of supervision of the resident when it corresponds with the progress note. By signing the note the senior resident concurs with the note as written. If there is additional information required or a correction/clarification of the note is required the attending/chief resident will include his own note. The senior resident may add additional information as required or have the resident add the information as long as the attending/chief resident signs or supervision is documented by the resident in the progress note.
8. Participate in medication rounds and treatment planning
9. Review Narrative Summaries and Medical Evaluation Boards (all narrative summaries also require attending staff signature).
10. Assist with discharge planning.
11. Review patient safety and transfer to alternate levels of care. All discharges and transfers must be discussed with staff.
12. Provide supervision for routine ambulatory medical care (such as wound care and evaluation of medical complaints)
13. Review consultations other clinical services for specialty evaluation and care

14. Assist in supervision and education of PGY1 and PGY2 residents, including management of morning report and clinical case conferences
15. Supervise medical students
16. Review peer chart review quality assurance documentation.

PGY4 residents serve in the role of Subattending. They provide routine supervision for all aspects of clinical care. They must obtain two hours of staff supervision per week regarding both the nature of clinical care provided by the service and their skills as clinical supervisors.

### **Outpatient**

1. Evaluate new patients assigned to residents performing and documenting a history and physical examination or resident accept note for all new patients on the date of first visit. Each new patient must be reviewed by staff within 48 hours of the visit and the record must have documented evidence of staff supervision. All new child and adolescent evaluations will be under direct staff supervision.
2. Prescribe medication.
3. Perform psychotherapy (individual, family, couples and group)
4. Perform command consultation.
5. Conduct security evaluations (under supervision of forensic service faculty or fellow)
6. Perform TDRL evaluations
7. Assist in sanity board examinations (under qualified staff supervision)
8. Document changes in clinical status, diagnosis, prognosis, and treatment changes in progress notes for each clinical visit. All charts must be reviewed by staff every 6 visits or every four months (whichever is sooner)
9. Participate in clinical case conferences
10. Prepare Medical Evaluation Boards
11. Determine (under staff supervision) patient safety and transfer to alternate levels of care. All patients viewed as dangerous must be discussed with staff before they leave the treatment area.
12. Consult other clinical services for specialty evaluation and care
13. Supervise medical students

Senior residents maintain a continuity clinic (approximately 4 hours per week) and are expected to manage one to two long term psychotherapy cases and 8 to 10 medication/supportive therapy cases. They are to arrange supervision with a qualified staff member of their choice.

### **Restrictions of practice:**

1. All inpatients must have a staff attending evaluation performed and documented within 24 hours of admission.
2. All narrative summaries must have attending staff signatures.

### **Consultation Liaison / Geriatric Service:**

1. Evaluate new patients assigned to residents performing and documenting a history and physical examination or resident accept note for all new patients.
2. Provide consultation recommendations including use of medication, psychotherapy, environmental changes, and nursing practices. All recommendations must be reviewed by staff, but may be entered into the clinical record prior to formal review.
3. Perform psychotherapy (individual and group).
4. Assist staff in performance of electro-convulsive therapy
5. Perform command consultation.
6. Document changes in clinical status, diagnosis, prognosis, and treatment changes in progress notes in the frequency specified for the clinical service.

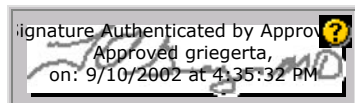
7. Participate in medication rounds and treatment planning – assist in training of junior residents
8. Assist with discharge planning.
9. Determine (under staff supervision) patient safety and transfer to alternate levels of care.
10. Conduct emergency department evaluations of patients and supervise PGY1 residents in initial evaluations
11. Provide ambulatory services (under staff or fellow supervision) at the Soldiers and Airmen's retirement home
12. Evaluate and provide treatment recommendations (under neurology staff supervision) patient presenting with neurobehavioral complaints
13. Supervise medical students

**On Call (NNMC and MGMC from home):**

1. Evaluate of patients in the emergency department, hospital (and air evacuation) transfers, and hospital consultations
2. Document new evaluations and changes in care
3. Personally evaluate all patients admitted to the adolescent unit at NNMC.
4. Carry and respond to all pages to the on-call pager (emergency department, outside physicians, commands, and patient questions)
5. Assist when requested with transfers and acceptances from other services
6. Assess patient needing restraint and provide restraint orders as appropriate

**Restrictions of practice:**

1. All discharges from the units or emergency department must be discussed with the staff on call prior to the discharge.
2. All restraints must be discussed with staff.
3. All hospital consultations must be discussed with staff before the recommendations are entered into the official records.
4. All other admissions must be presented and discussed during morning report the following morning



**PGY-1 RESIDENT COMPETENCY CHECKLIST**

Resident Name		
Review Period		-
	Competency Element Comp=competent NI=needs improvement Sup=superior	
<u>1</u>	Understands basic etiology, pathology, diagnosis, treatment, prognosis, and prevention of the medical, neurological, and psychiatric disorders that are commonly encountered in medical practice. ( <i>medical knowledge</i> )	<u>Comp</u>
<u>2</u>	Is proficient in undertaking the initial clinical and laboratory studies of patients presenting with a broad range of common medical and surgical disorders ( <i>medical knowledge/patient care</i> )	<u>Comp</u>
<u>3</u>	Is proficient in interviewing patients with medical, neurological and psychiatric disorders, obtaining a complete range of relevant biological, psychological and social information in an effective and efficient manner ( <i>communication</i> )	<u>Comp</u>
<u>4</u>	Is proficient in appropriate use of collateral contacts (family members, friends, work supervisors and peers, governmental agencies, etc.) in obtaining relevant information and arranging for patient referral and disposition( <i>communication/</i> )	<u>Comp</u>
<u>5</u>	Is proficient in conducting a complete physical examination, including a complete mental status examination and a complete neurological examination ( <i>medical skill / communication</i> )	<u>Comp</u>
<u>6</u>	Is able to diagnose common medical and surgical disorders and formulate appropriate initial treatment plan ( <i>medical knowledge/ patient care</i> )s	<u>Comp</u>
<u>7</u>	Is able to provide limited, but appropriate, continuous care of medical illnesses and to make appropriate referrals ( <i>patient care/systems based practice</i> )	<u>Comp</u>
<u>8</u>	Is sufficiently familiar with medical, neurological and psychiatric treatment modalities that are commonly used, so as to be able to treat selected cases and to manage with supervision on an ongoing basis ( <i>medical knowledge/patient care</i> )	<u>Comp</u>
<u>9</u>	Is cognizant of the nature of the interactions between psychiatric treatments and medical and surgical treatments ( <i>knowledge</i> )	<u>Comp</u>
<u>10</u>	Is able to relate to patients and their families, as well as to other members of the health care team, with compassion, respect, and professional integrity( <i>communication/ethics/professionalism</i> )	<u>Comp</u>
<u>11</u>	Integrates the attitudes and values of a physician with those of a military officer ( <i>professionalism</i> )	<u>Comp</u>
<u>12</u>	Demonstrates a readiness to seek assistance when appropriate ( <i>professionalism/practice based improvement</i> )	<u>Comp</u>
<u>13</u>	Demonstrates commitment to learning and patient care by promptness, availability, and thoroughness to completion of responsibilities ( <i>professionalism</i> )	<u>Comp</u>
<u>14</u>	Has a basic knowledge about psychiatric disorders which may mimic medical conditions, and medical disorders which may mimic psychiatric conditions ( <i>knowledge</i> )	<u>Comp</u>
<u>15</u>	Is familiar with basic forensic and ethical issues commonly encountered in medical and psychiatric practice, such as commitment, involuntary hospitalization, informed consent, right to refuse treatment, etc ( <i>professionalism/systems of care</i> )	<u>Comp</u>

Signatures/Date

Resident

Program Director

**PGY-2 RESIDENT COMPETENCY CHECKLIST**

Resident Name		
Review Period		-
	Competency Element Comp=competent NI=needs improvement Sup=superior	
<u>1</u>	Interview patients effectively, and conduct a comprehensive psychiatric examination, including a complete developmental history and mental status exam <i>(communication/patient care)</i>	<u>Comp</u>
<u>2</u>	Record histories and physical examinations clearly and in sufficient detail to produce a meaningful, continuous record of a patient's personal background, illness, and course of treatment <i>(patient care/systems based practice/professionalism)</i>	<u>Comp</u>
<u>3</u>	Consistently and reliably perform all administrative/record-keeping requirements <i>(professionalism)</i>	<u>Comp</u>
<u>4</u>	Orally present/discuss patients in a concise, well-organized, & thoughtful manner <i>(communication)</i>	<u>Comp</u>
<u>5</u>	Having a thorough understanding of the official psychiatric diagnostic system <i>(medical knowledge)</i>	<u>Comp</u>
<u>6</u>	Provide psychiatric treatment as applied to inpatient psychiatry, including: multi-disciplinary ward milieu therapy, psychopharmacology, electroconvulsive therapy, and individual and group therapy <i>(medical knowledge/patient care/systems based/communication/ professionalism)</i>	<u>Comp</u>
<u>7</u>	Have a working knowledge of the current psychiatric literature and recent advances in general psychiatry, especially in relation to diagnosis, treatment, and prognosis of disorders commonly encountered in inpatient psychiatry <i>(medical knowledge /professionalism / practice based learning and improvement)</i>	<u>Comp</u>
<u>8</u>	Apply principles of medical ethics to psychiatric practice <i>(professionalism)</i>	<u>Comp</u>
<u>9</u>	Understand the roles of other mental health providers in health delivery systems <i>(systems based practice)</i>	<u>Comp</u>
<u>10</u>	Possess a working knowledge of the community mental health system and understand the rationale for a graded approach to the delivery of mental health care from less restrictive to more restrictive options including appropriate discharge planning and aftercare <i>(systems based practice/ medical knowledge)</i>	<u>Comp</u>
<u>11</u>	Provide care to chronically mentally ill patients utilizing pharmacologic, psychosocial, behavioral and psychotherapeutic treatment methods <i>(medical knowledge/systems based practice)</i>	<u>Comp</u>
<u>12</u>	Manage detoxification, stabilization and initial management of patients with substance-related disorders, including understanding the 12-step principles <i>(medical knowledge/ patient care)</i>	<u>Comp</u>
<u>13</u>	Perform complete emergency evaluations and psychiatric consultations <i>(communication / systems of care)</i>	<u>Comp</u>
<u>14</u>	Assess, diagnose and manage dangerous patients using psychosocial, somatic and psychotherapeutic treatment methods <i>(knowledge/skills/communication/systems of care)</i>	<u>Comp</u>
<u>15</u>	Possess a basic understanding of clinical psychopharmacology and the theoretical basis for modern pharmacotherapy <i>(knowledge)</i>	<u>Comp</u>
<u>16</u>	Be effectively involved in teaching third and fourth year medical students and students in other health professions <i>(communication)</i>	<u>Comp</u>

Signatures/Date

Resident

Program Director

### PGY-3 RESIDENT COMPETENCY CHECKLIST

Resident Name		
Review Period		-
	Competency Element Comp=competent NI=needs improvement Sup=superior	
<u>1</u>	Understand the nature of the therapeutic contract in the outpatient setting ( <i>medical knowledge/ communication patient care</i> )	<u>Comp</u>
<u>2</u>	Gather comprehensive history and perform skilled mental status exam ( <i>communication / patient care</i> )	<u>Comp</u>
<u>3</u>	Formulate a patient's current and past life experiences leading to an accurate, relevant, and comprehensive diagnosis ( <i>medical knowledge / patient care</i> )	<u>Comp</u>
<u>4</u>	Develop initial treatment plans that are efficient and cost effective.( <i>patient care /systems based practice</i> )	<u>Comp</u>
<u>5</u>	Cognitive psychotherapy (1) ( <i>medical knowledge / patient care / communication</i> )	<u>Comp</u>
<u>6</u>	Brief individual psychodynamic psychotherapy (1) ( <i>medical knowledge / patient care / communication</i> )	<u>Comp</u>
<u>7</u>	Long-term individual psychotherapy (1) ( <i>medical knowledge / patient care / communication</i> )	<u>Comp</u>
<u>8</u>	Time-limited group psychotherapy (1) ( <i>medical knowledge / patient care / communication</i> )	<u>Comp</u>
<u>9</u>	Long-term group psychotherapy (1) ( <i>medical knowledge / patient care / communication</i> )	<u>Comp</u>
<u>10</u>	Combined Pharmacotherapy/Supportive Psychotherapy (20) ( <i>medical knowledge / patient care / communication</i> )	<u>Comp</u>
<u>11</u>	Marital or couples therapy (1) ( <i>medical knowledge / patient care / communication</i> )	<u>Comp</u>
<u>12</u>	Family therapy (1)( <i>medical knowledge / patient care / communication</i> )	<u>Comp</u>
<u>13</u>	Comprehensive Child/adolescent evaluations (6) ( <i>medical knowledge / patient care / communication</i> )	<u>Comp</u>
<u>14</u>	Intermediate/long term child or adolescent therapy case (1) ( <i>medical knowledge / patient care / communication</i> )	
<u>15</u>	Capacity/responsibility (Sanity board) (1) ( <i>medical knowledge / communication</i> )	<u>Comp</u>
<u>16</u>	Administrative/quality review (Board for correction of records) (1)( <i>skill/communication</i> )	<u>Comp</u>
<u>17</u>	Complete record-keeping record review and administrative requirements in a timely manner( <i>professionalism / system based practice/ practice based improvement</i> )	<u>Comp</u>
<u>18</u>	Develop the ability to understand and utilize personal reactions stimulated by patient interactions in the ongoing provisions of psychotherapy( <i>medical knowledge/patient care/communication</i> )	<u>Comp</u>
<u>19</u>	Use knowledge of differential therapeutics, relative costs, and available resources to manage a patient population in an efficient manner( <i>systems based practice/ patient care</i> )	<u>Comp</u>
<u>20</u>	Work collaboratively with allied mental health professionals ( <i>professionalism / sytem based practice/patient care</i> )	<u>Comp</u>
<u>21</u>	Demonstrate effective time management skills( <i>professionalism/systems based practice</i> )	<u>Comp</u>
<u>22</u>	Manage patients at an appropriate level of treatment( <i>systems based practice</i> )	<u>Comp</u>
<u>23</u>	Be effective teachers of medical students and other providers ( <i>communications / practice based improvement</i> )	<u>Comp</u>
<u>24</u>	Demonstrate post disaster psychiatric skills - Perform and teach effectively at the operational military medicine exercise,( <i>medical knowledge/ systems based practice/professionalism</i> )	<u>Comp</u>
<u>25</u>	Demonstrate knowledge of ethical, moral, and military specific (i.e. fitness for duty) issues during the course of evaluation or treatment in the outpatient setting( <i>systems based practice/patient care</i> )	<u>Comp</u>

Signatures/Date

Resident

Program Director

**PGY-4 RESIDENT COMPETENCY CHECKLIST**

Resident Name		
Review Period		-
	Competency Element Comp=competent NI=needs improvement Sup=superior	
<u>1</u>	Have an appropriate level of skill in Military Administrative Procedures applicable to practice of psychiatry at any military medical organizational level( <i>systems based / practice based improvement</i> )	<u>Comp</u>
<u>2</u>	Be effective in consultation and liaison skills, including assessment, differential diagnosis, management recommendations, and working with medical professionals in other specialties( <i>communication / professionalism/ systems based / practice based</i> )	<u>Comp</u>
<u>3</u>	Possess an understanding of the organization, administration, and practical function of military and civilian community mental health services( <i>systems based / practice based /knowledge</i> )	<u>Comp</u>
<u>4</u>	Practice clinical skills by satisfactorily treating at least two long-term psychotherapy cases, at least 6 ongoing medication cases, and completing any requirements not satisfactorily met during the PGY-3 year( <i>practice based / patient care</i> )	<u>Comp</u>
<u>5</u>	Review clinical neurology and develop a sophisticated understanding as to how neurobiological processes create, affect, or sustain behavioral and emotional symptoms( <i>knowledge / patient care</i> )	<u>Comp</u>
<u>6</u>	Learn rapid assessment and efficient management techniques for use in the treatment of patients seen in a multidisciplinary partial hospital program, acting in the role of program consultant( <i>patient care / systems based</i> )	<u>Comp</u>
<u>7</u>	Develop appropriate skills in designing, completing and presenting clinical research or other approved scholarly project, and in critically evaluating research presented in the psychiatric literature.( <i>knowledge / practice based</i> )	<u>Comp</u>
<u>8</u>	Demonstrate theoretical and practical understanding of geriatric psychiatry( <i>knowledge / patient care</i> )	<u>Comp</u>
<u>9</u>	Perform effectively in a supervised experience in taking call from home ( <i>systems based / patient care</i> )	<u>Comp</u>
<u>10</u>	Become effective teachers of medical students, junior residents and colleagues( <i>teaching / professionalism/ communication</i> )	<u>Comp</u>
<u>11</u>	Demonstrate competence during supervised experiences away from medical centers and in other multidisciplinary mental health and multi-specialty medical settings( <i>Systems based / patient care</i> )	<u>Comp</u>
<u>12</u>	Function effectively as teacher, supervisor, and triager in the role of inpatient psychiatry sub-attending( <i>patient care / systems based / communication</i> ).	<u>Comp</u>
<u>13</u>	Supervise Quality Improvement programs on clinical services ( <i>Practice based improvement</i> )	<u>Comp</u>

Signatures/Date

Resident

Program Director

**General Psychiatry Rotations**  
(2002-2003)  
22 April 2002 version

**PGY1 Year:** (13 four-week rotations)

2	2 Inpatient Psychiatry	WRAMC
1	1 Consultation Psychiatry	WRAMC
3	3 Inpatient Medicine (2 only for Navy)	WRAMC for Army – NNMC for Navy
2	2 Ambulatory Medicine (1 only for Navy)	WRAMC for Army – NNMC for Navy
1	1 Emergency Medicine	MGMC for all
1	1 Medical ICU	WRAMC for Army – NNMC for Navy
1	1 Inpatient Neurology	WRAMC
1	1 Outpatient Neurology	NNMC
1	1 GYN/PEDS – Navy Only (psychiatry call)	NNMC
1	1 Ambulatory Orthopedics (Navy Only)	NNMC
1	1 Elective	TBD

Ambulatory medicine and ICU rotations may be deleted as needed for DO interns

**PGY2 Year:** (13 four-week rotations)

1	Night/Emergency Psychiatry	WRAMC
7	Inpatient/APPHP	WRAMC
1	Addiction	MGMC
1	Adolescent Inpatient Psychiatry	NNMC
3	Inpatient Chronic Units	NVMHI

**PGY3 Year:** (13 four-week rotations)

13	Outpatient Psychiatry (One half day is in child/adolescent)	
----	---	--

**PGY4 Year:** (13 four-week rotations)

3	Subattending Inpatient Service	WRAMC
2	Consultation Liaison Service	WRAMC
1	Geriatric Service	WRAMC
2	Continuity Services / Community	WRAMC MCCC
5	Electives	Multiple

## Didactic Course Work:

Please note that residents are expected to attend all “elective, strongly encouraged” conferences. Since these conferences occur during duty hours and not during the protected Wednesday afternoon didactic period, acute patient care matters may preclude attendance of some residents. While it is expected that residents will attend approximately 70% of these conferences, these conferences are therefore included in the mandatory, attendance category for which attendance data is collected. Attendance information is collected for all “required” didactic experiences which occur during the protected didactic time on Wednesday afternoons.

Course #	Title	Year(s) Offered	Required/Elective	Hours (per year)
<b>PGY1 and Multi-Year Conferences and Classes</b>				
101,201,301,401	Grand Rounds	PGY1, PGY2, PGY3, PGY4	Required	12, 40, 40, 40
102	Intern Clinic Introduction to Psychiatry	PGY1	Required	40
103, 202, 402	Inpatient Morning Report	PGY1, PGY2, PGY4	Elective	40, 100, 60
104, 203, 403	Inpatient Clinical Case Conference	PGY1, PGY2, PGY4	Elective	4, 20, 12
105, 204, 404	Continuity Care Clinical Case Conference	PGY1, PGY2, PGY4	Elective	4, 8, 8
106, 405	Consultation Service Case Conference	PGY1, PGY4	Elective	4, 12
<b>PGY2 Conferences and Classes</b>				
205	Basic Psychiatry	PGY2	Required	46
206	Orientation	PGY2	Required	7
207	Growth and Development	PGY2	Required	29
208	Family and Couples Therapy	PGY2	Required	12
209	Introduction to Psychotherapy	PGY2	Required	6
210	Group Therapy	PGY2	Required	7
211	Training Group	PGY2	Required	29
212	Psychological Assessment	PGY2	Required	2
<b>PGY3 Conferences and Classes</b>				
302	Cognitive Behavioral Psychotherapy	PGY3	Required	13
303	Outpatient Group therapy	PGY3	Required	5
304	Advanced Family and Couples Therapy	PGY3	Required	7
305	Introduction to Psychodynamic Treatments	PGY3	Required	20
306	Child Pathology	PGY3	Required	14
307	Brief Dynamic Treatments	PGY3	Required	10
308	Medical Hypnosis	PGY3	Required	10
309	Neuroscience	PGY3	Required	44
310	Dynamic Theory and Selected Topics	PGY3	Required	15
311	Health Economics	PGY3	Required	5

312	Outpatient Case Conference	PGY3	Elective	45
<b>Pgy4 conferences and Classes</b>				
406	Dynamic Therapy and Selected Topics	PGY4	Required	12
407	Evidenced Based Medicine	PGY4	Required	10
408	Hypnosis Treatment	PGY4	Required	5
409	Social Cultural Psychiatry	PGY4	Required	5
410	Military Psychiatry	PGY4	Required	23
411	Sexuality	PGY4	Required	5
412	Ethics	PGY4	Required	4
413	Geriatric Psychiatry	PGY4	Required	8
414	Psychiatry Review	PGY4	Required	28
415	Oral Board Review	PGY4	Required	8
416	Forensic Psychiatry	PGY4	Required	7
417	Neurology Review	PGY4	Required	14
418	Geriatric Srvice Clinical Conference	PGY4	Elective	4

PGY1 residents are scheduled for 52 hours of mandatory conferences in psychiatry and 56 hours of elective conferences

PGY2 residents are scheduled for 178 hours of mandatory conferences and 128 hours of elective conferences.

PGY3 residents are scheduled for 183 hours of mandatory conferences and 45 hours of elective conferences.

PGY4 residents are scheduled for 169 hours of mandatory conferences and 96 hours of elective conferences.

During the four years of training 582 hours of mandatory conferences and 325 hours of elective conferences are offered.

## **Post Graduate Year One Conferences and Didactic Courses**

101	<b>Grand Rounds</b>
a.	Required PGY1, PGY2, PGY3, PGY4, PGY5 (while on psychiatry service)
b.	Full time and invited faculty
c.	Psychiatry and other (e.g., psychology, social work, policy makers, epidemiologists, and neuroscience)
d.	Full time and part time
e.	Updates in topics including neurosciences, clinical research, and clinical management. Local and national subject matter experts present summaries of clinical best practices and recent research. All presentations are certified by ACCME for Category 1 continuing education credits.
f.	Weekly for one hour from September through June (approximately 12 hours during PGY1)

102	<b>Intern Clinic Introduction to Psychiatry</b>
a.	Required PGY1 when not on unit or emergency medicine rotations
b.	Intern clinic supervisors at each site
c.	Psychiatry
d.	Full time
e.	Discussion of basic concepts of psychiatric assessment, diagnosis, pharmacotherapy, supportive psychotherapy, administrative psychiatry, compensation evaluation, systems based medicine, and community psychiatry. Lectures/seminars precede the intern continuity clinic to provide residents with the opportunity to relate topics to patients they have recently seen or will be seeing in clinic that day.
f.	Weekly for one hour immediately preceding intern continuity clinic (approximately 40 hours)

103	<b>Inpatient Morning Report</b>
a.	Elective (strongly encouraged) PGY1, PGY2, PGY4 when on inpatient service
b.	Faculty: Dr. Nam and senior residents on service
c.	Psychiatry
d.	Full time
e.	Residents present cases admitted overnight, including a bio-psycho-social formulation of a selected case. Residents and staff discuss safety assessment, systems based practice (admission criteria, involuntary admission statutes, and transfer between institutions), communication skills (evaluating agitated or psychotic patients and obtaining collateral information from other sources), and clinical management principles relating to the cases presented. Senior residents will often present practice guidelines or recent journal articles relating to cases being presented.
f.	Daily (Monday – Friday) for one hour (approximately 40 hours during PGY1)

104	<b>Inpatient Clinical Case Conference</b>
a.	Elective (strongly recommended) PGY1, PGY2, PGY4 when on inpatient service

b.	Faculty: Senior residents on service and invited full time faculty
c.	Psychiatry
d.	Full time
e.	Case presentations and discussions of diagnosis and treatment; selected topics of clinical management. PGY1 and PGY2 residents present cases and use data to engage in a formal bio-psycho-social formulation of the case. Senior residents also present recent journal articles in a “journal club” style relating to patients recently treated on the inpatient adult psychiatry unit. Faculty provide critical analysis of the papers.
f.	Weekly for one hour (approximately 4 hours during PGY1)

105	<b>Continuity Care Clinical Case Conference</b>
a.	Elective (strongly recommended) PGY1, PGY2, PGY4 when on continuity/adult partial hospitalization service
b.	Faculty: Dr. Gray
c.	Psychiatry
d.	Part time
e.	Cases are presented and discussed with a senior psychoanalyst who guides residents through the process of psychodynamic formulation and treatment planning (short term and long term). The patients discussed in this conference generally have severe new onset or chronic mental illness (including psychotic disorders and severe mood or personality disorders). Treatment considerations include use of medication, selection of psychotherapy, and social / environmental factors that are affecting the course of illness. Elements of psychosocial rehabilitation are strongly emphasized, including likely difficulties with patient adherence to prescribed treatment. APA practice guidelines relating to patient diagnoses are also discussed.
f.	Weekly for one hour while on clinical service (approximately 4 hours during PGY1)

106	<b>Consultation Service Clinical Case Conference</b>
a.	Elective (strongly encouraged) PGY1, PGY4 when on consultation and geriatric services
b.	Faculty: Dr. Wain, Ph.D. and Dr. Stasinos, M.D.
c.	Psychology and Psychiatry
d.	Full time
e.	Cases are presented followed by of diagnosis and treatment; selected topics of clinical management and models of consultation. Selected patients may be brought into the conference for “bedside” style teaching relating to interview techniques, psychodynamic formulation and therapy techniques. Approximately half of the patients presented have chronic pain, somatoform, conversion, or dissociative symptoms. Relaxation and hypnosis techniques are discussed in addition to pharmacological and more traditional psychotherapy techniques.
f.	Weekly for one hour (approximately 4 hours during PGY1)

## **Post Graduate Year Two Conferences and Didactic Courses**

201	<b>Grand Rounds</b>
a.	Required PGY1, PGY2, PGY3, PGY4, PGY5 (while on psychiatry service)
b.	Invited faculty
c.	Psychiatry and other
d.	Full time and part time
e.	Updates in topics including neurosciences, clinical research, and clinical management. Local and national subject matter experts present summaries of clinical best practices and recent research. All presentations are certified by ACCME for Category 1 continuing education credits.
f.	Weekly for one hour from September through June (approximately 40 hours during PGY2)

202	<b>Inpatient Morning Report</b>
a.	Elective (strongly encouraged) PGY1, PGY2, PGY4 when on inpatient service
b.	Faculty: Dr. Nam and senior residents on service
c.	Psychiatry
d.	Full time
e.	Residents present cases admitted overnight, including a bio-psycho-social formulation of a selected case. Residents and staff discuss safety assessment, systems based practice (admission criteria, involuntary admission statutes, and transfer between institutions), communication skills (evaluating agitated or psychotic patients and obtaining collateral information from other sources), and clinical management principles relating to the cases presented. Senior residents will often present practice guidelines or recent journal articles relating to cases being presented.
f.	Daily (Monday – Friday) for one hour (approximately 100 hours during PGY2)

203	<b>Inpatient Clinical Case Conference</b>
a.	Elective (strongly recommended) PGY1, PGY2, PGY4 when on inpatient service
b.	Faculty: Senior residents on service and invited full time faculty
c.	Psychiatry
d.	Full time
e.	Case presentations and discussions of diagnosis and treatment; selected topics of clinical management. PGY1 and PGY2 residents present cases and use data to engage in a formal bio-psycho-social formulation of the case. Senior residents also present recent journal articles in a “journal club” style relating to patients recently treated on the inpatient adult psychiatry unit. Faculty provide critical analysis of the papers.
f.	Weekly for one hour (approximately 20 hours during PGY2)

204	<b>Continuity Care Clinical Case Conference</b>
a.	Elective (strongly recommended) PGY1, PGY2, PGY4 when on continuity/adult partial hospitalization service

b.	Faculty: Dr. Gray
c.	Psychiatry
d.	Part time
e.	Cases are presented and discussed with a senior psychoanalyst who guides residents through the process of psychodynamic formulation and treatment planning (short term and long term). The patients discussed in this conference generally have severe new onset or chronic mental illness (including psychotic disorders and severe mood or personality disorders). Treatment considerations include use of medication, selection of psychotherapy, and social / environmental factors that are affecting the course of illness. Elements of psychosocial rehabilitation are strongly emphasized, including likely difficulties with patient adherence to prescribed treatment. APA practice guidelines relating to patient diagnoses are also discussed
f.	Weekly for one hour while on clinical service (approximately 8 hours during PGY2)

205	<b>Basic Psychiatry</b>
a.	Required PGY2
b.	Faculty: Drs Lacy, Griffeth, Reeves and invited faculty
c.	Psychiatry
d.	Full time and part time
e.	Introduction of basic aspects of psychiatry including epidemiology, diagnosis, pathophysiology, pharmacotherapy, and environmental management issues based on categories of psychiatric disease. The course uses the American Psychiatric Press Textbook of Psychiatry as the primary source for readings, along with supplementary articles.
f.	Weekly for one hour for 46 weeks (46 hours)

206	<b>Orientation</b>
a.	Required PGY2
b.	Faculty: Dr. Nam and others
c.	Psychiatry
d.	Full time
e.	Covers basic aspects of call responsibilities and emergent evaluations of adults and children as well as practical aspects of administrative and systems based practice. Systems based practice is emphasized with regard to transfer of care across levels of care and between facilities. Safety assessment, competency evaluations, and disability evaluations are also addressed.
f.	Weekly for one hour for 7 sessions (7 hours)

207	<b>Growth and Development</b>
a.	Required PGY2
b.	Faculty: Dr. Cozza
c.	Psychiatry
d.	Full time

e.	Covers cognitive and psychological development from birth through adulthood. The course uses textbook and selected journal readings that cover multiple theories of development.
f.	Weekly for one hour for 29 weeks (29 hours)

208	<b>Family and Couples Therapy</b>
a.	Required PGY2
b.	Faculty: Dr. Privatera and Ms. Snow
c.	Psychiatry and social work
d.	Part time
e.	Covers issues of family and couples dynamics and approaches to therapeutic interventions. The course uses readings, videotaped vignettes, and case material provided by residents.
f.	Weekly for two hours for 6 weeks (12 hours total).

209	<b>Introduction to Psychotherapy</b>
a.	Required PGY2
b.	Faculty: Dr. Lacy
c.	Psychiatry
d.	Full time
e.	Covers basic aspects of psychotherapy and the physician patient relationship common to all forms of psychotherapy in preparation for the specific psychotherapy courses provided during PGY3. Using case based materials residents identify key therapeutic tools and pitfalls.
f.	Weekly for one to two hours for 6 sessions (6 hours)

210	<b>PGY2 Group Seminar</b>
a.	Required PGY2
b.	Faculty: Dr. Waldrep and Mr. Keller
c.	Psychiatry, Nursing Services
d.	Full time
e.	Discusses basic principles of group therapy as it is applied in the inpatient or adult partial hospital settings. Core therapeutic factors in group therapy are reviewed along with appropriate inclusion and exclusion factors for selection of patients for group therapy and management of challenging situations that present during therapy.
f.	Weekly for one hour for 7 weeks (7 hours)

211	<b>Training Group</b>
a.	Required PGY2
b.	Faculty: Dr. Allen
c.	Psychiatry
d.	Part time

e.	Provides the opportunity for residents to experience participation as a group member and then discuss the experience with a confidential facilitator. Residents are provided an overview of possible goals of group and then negotiate their personal goals and boundaries of content and confidentiality. This experience also provides the PGY2 residents an opportunity to interact with all members of their year through most of the year and is seen to enhance cohesion within the residency.
f.	Weekly for one hour for 29 weeks (29 hours)

212	<b>Psychological Assessment</b>
a.	Required PGY2
b.	Faculty: Dr. Jones
c.	Psychology
d.	Full time
e.	Discusses indications, administration, and interpretation of a variety of psychological testing instruments. MMPI, MCMI, projective testing, and neuropsychiatric testing are reviewed. Dr. Jones is also the staff member who performs psychological testing on the inpatient and partial hospital services. Residents routinely review the results of psychological testing on their patients with Dr. Jones during their inpatient and partial hospital rotations. This course serves to consolidate their knowledge of tests which they have already had the experience to use in clinical practice.
f.	Weekly for one hour for 2 weeks. (2 hours)

## **Post Graduate Year Three Conferences and Didactic Courses**

301	<b>Grand Rounds</b>
a.	Required PGY1, PGY2, PGY3, PGY4, PGY5 (while on psychiatry service)
b.	Invited faculty
c.	Psychiatry and other
d.	Full time and part time
e.	Updates in topics including neurosciences, clinical research, and clinical management. Local and national subject matter experts present summaries of clinical best practices and recent research. All presentations are certified by ACCME for Category 1 continuing education credits.
f.	Weekly for one hour from September through June (approximately 40 hours in PGY3)

302	<b>Cognitive Behavioral Psychotherapy</b>
a.	Required PGY3
b.	Faculty: Dr. Grieger
c.	Psychiatry
d.	Full time
e.	Discusses indications for, patient selection and treatment principles of cognitive behavioral therapy. Residents are presented the concepts of cognitive formulation and specific treatment techniques.
f.	Weekly for one hour for 13 sessions (13 hours)

303	<b>Outpatient Group Therapy</b>
a.	Required PGY3
b.	Faculty: Dr. Lyszczarz
c.	Psychiatry
d.	Full time
e.	Discusses patient selection, treatment planning and treatment implementation for outpatient group therapy.. Residents bring in case material from their work in adult outpatient clinics. Short term and long term groups are discussed with emphasis on the therapeutic factors and aspects of treatment challenges (non-attendance, communication between patients outside group setting, providers treating patients in both individual and group settings, expressed suicidality, and intoxicated patients).
f.	Weekly for one hour for 5 sessions (5 hours)

304	<b>Advanced Family/Couples Therapy</b>
a.	Required PGY3
b.	Faculty: Dr. Privatera, Ms. Snow
c.	Psychiatry, Social work
d.	Part time

e.	In this course residents are taught aspects of patient selection, treatment planning and treatment implementation. Residents bring in case material from their work in adult and child and adolescent outpatient clinics. Seminars address issues of patient roles within families, communication among family members, and methods of combined individual patient, family, and couples treatments. The teachers in this course also serve as the primary clinical supervisors for family and couples cases selected by the residents.
f.	Weekly for one hour for 7 sessions (7 hours)

<b>305</b>	<b>Introduction to Psychodynamic Treatments</b>
a.	Required PGY3
b.	Faculty: Dr. Cassimatis
c.	Psychiatry
d.	Part time
e.	Discusses indications for, patient selection and treatment principles of psychodynamic therapies. This course uses a collection of classic articles on the theory and practice of psychodynamic therapy as well as selected chapters from Dr. Gabbard's text on Psychodynamic Psychiatry in Clinical Practice. Dr. Cassimatis is a highly experienced psychoanalyst who also previously served as a residency program director. Residents are encouraged to bring in case material and to discuss the challenges they encounter in trying to apply the principles to dynamic therapy in their clinical practice.
f.	Weekly for one hour for 20 sessions (20 hours)

<b>306</b>	<b>Child Pathology</b>
a.	Required PGY3
b.	Faculty: Dr. Waldrep
c.	Psychiatry
d.	Full time
e.	This course provides an overview of the spectrum of psychiatric conditions that present during childhood and adolescence. Specific elements of diagnosis, variations in presentation, longitudinal course of illness and pharmacological and psychotherapeutic approaches to treatment are addressed. Residents are encouraged to discuss clinical material from their child and adolescent clinic experiences.
f.	Weekly for one hour for 14 sessions (14 hours)

<b>307</b>	<b>Brief Dynamic Treatments</b>
a.	Required PGY3
b.	Faculty: Dr. Ursano
c.	Psychiatry
d.	Full time
e.	This course discusses indications for, patient selection and treatment principles of brief dynamic therapy. Classic journal articles as well as case material provided by residents are used to integrate the principles into clinical practice. Dr. Ursano is a highly experienced psychoanalyst, Chairman and Professor of Psychiatry, and co-author of the APPI textbook of Psychodynamic Psychotherapy. He serves as clinical supervisor for short term and long term dynamic cases for approximately one third of the residents during their outpatient clinic year.

f.	Weekly for one hour for 10 sessions (10 hours)
----	--

308	<b>Medical Hypnosis</b>
a.	Required PGY3
b.	Faculty: Dr. Wain
c.	Psychology
d.	Full time
e.	This course provides an overview of patient assessment and techniques for performing hypnosis. This is an introductory course that covers primarily theoretical aspects of hypnosis in clinical practice. A follow on course during PGY4 provides greater emphasis on actual technique
f.	Weekly for one to two hours (10 hours total)

309	<b>Neuroscience</b>
a.	Required PGY3
b.	Faculty: Dr. Lacy and invited neuroscientists and clinicians
c.	Psychiatry and basic sciences
d.	Full time and part time
e.	Provides an in depth review of neuroanatomy, histopathology, gene transduction, and psychopharmacology for selected psychiatric disorders. Guest speakers from the department of neurology, as well as clinical research scientists from the NIMH, NIAAA, NIDA, and the Stanley Foundation serve as invited faculty. In addition to text readings, residents are presented new research on functional imaging, neuronal networks, and molecular studies. Neuroanatomy with clinical correlations is emphasized with the use of preserved human brain specimens from patients who suffered from schizophrenia and bipolar disorder during life.
f.	Weekly for one to two hours (total of 44 hours)

310	<b>Dynamic Theory and Selected Topics</b>
a.	Required PGY3
b.	Faculty: Dr. Waldrep and selected guest faculty
c.	Psychiatry
d.	Full time and part time
e.	Provides an overview of selected topics related to the history of psychiatry, classic articles, and issues not covered in other courses. This is a new course this year – it is being developed to replace a “classic dynamic theory” course that received negative reviews by residents and recent graduates of the program. The new course will include “secondary source” reviews of dynamic theories rather than “primary source” readings. The course will also include elements of community / public sector psychiatry, disaster psychiatry, psychiatric practice under managed care. Guest faculty will include psychiatrists in private practice, HMOs, and state and federal healthcare systems.
f.	Weekly for one or two hours (15 hours)

311	<b>Health Economics</b>
a.	Required PGY3

b.	Faculty: Dr. Cozza
c.	Psychiatry
d.	Full time
e.	This course provides an overview of issues of systems based practice, resource allocation, quality assurance monitoring and improvement, and workload tracking. Residents will be presented with current psychiatric coding guidelines for billing of inpatient and outpatient psychiatric care under current federal guidelines as well as a review of systems within the Department of Defense and Department of Veterans Affairs for internal cost / service monitoring
f.	Weekly for one to two hours (5 hours total)

312	<b>Outpatient Case Conference</b>
a.	Elective – strongly encouraged
b.	Faculty – selected site faculty (Drs. Grieger, Lyszcza, and Lacy are primary at the three sites)
c.	Psychiatry
d.	Full time and part time
e.	This conference is designed to assist residents in the transition between inpatient and outpatient psychiatric practice. At each site the residents and selected faculty meet weekly to discuss clinical case material to examine issues of diagnosis and clinical management. Residents are invited to consider multiple approaches to psychotherapeutic and pharmacological treatments, management of chronic and complex cases, and their personal experience as an outpatient clinician. During the second half of the year residents are provided an overview of the process and goals of the ABPN oral board examination process. Residents then interview actual patients and provide formulation and case discussion in the format of the ABPN oral examinations – non-interviewing residents observe the interview and presentation from an adjoining observation room. Residents are provided feedback with regard to their conduct of the interview, presentation of the case and proposed treatments.
f.	Weekly for on hour (45 hours)

## **Post Graduate Year Four Conferences and Didactic Courses**

401	<b>Grand Rounds</b>
a.	Required PGY1, PGY2, PGY3, PGY4, PGY5 (while on psychiatry service)
b.	Invited faculty
c.	Psychiatry and other
d.	Full time and part time
e.	Updates in topics including neurosciences, clinical research, and clinical management. Local and national subject matter experts present summaries of clinical best practices and recent research. All presentations are certified by ACCME for Category 1 continuing education credits.
f.	Weekly for one hour from September through June (40 hours during PGY4)

402	<b>Inpatient Morning Report</b>
a.	Elective (strongly encouraged) PGY1, PGY2, PGY4 when on inpatient service
b.	Faculty: Dr. Nam and senior residents on service
c.	Psychiatry
d.	Full time
e.	Residents present cases admitted overnight, including a bio-psycho-social formulation of a selected case. Residents and staff discuss safety assessment, systems based practice (admission criteria, involuntary admission statutes, and transfer between institutions), communication skills (evaluating agitated or psychotic patients and obtaining collateral information from other sources), and clinical management principles relating to the cases presented. Senior residents will often present practice guidelines or recent journal articles relating to cases being presented.
f.	Daily (Monday – Friday) for one hour (60 hours during PGY4)

403	<b>Inpatient Clinical Case Conference</b>
a.	Elective (strongly recommended) PGY1, PGY2, PGY4 when on inpatient service
b.	Faculty: Senior residents on service and invited full time faculty
c.	Psychiatry
d.	Full time
e.	Case presentations and discussions of diagnosis and treatment; selected topics of clinical management. PGY1 and PGY2 residents present cases and use data to engage in a formal bio-psycho-social formulation of the case. Senior residents also present recent journal articles in a “journal club” style relating to patients recently treated on the inpatient adult psychiatry unit. Faculty provide critical analysis of the papers.
f.	Weekly for one hour (12 hours during PGY4)

404	<b>Continuity Care Clinical Case Conference</b>
a.	Elective (strongly recommended) PGY1, PGY2, PGY4 when on continuity/adult partial hospitalization service

b.	Faculty: Dr. Gray
c.	Psychiatry
d.	Part time
e.	Cases are presented and discussed with a senior psychoanalyst who guides residents through the process of psychodynamic formulation and treatment planning (short term and long term). The patients discussed in this conference generally have severe new onset or chronic mental illness (including psychotic disorders and severe mood or personality disorders). Treatment considerations include use of medication, selection of psychotherapy, and social / environmental factors that are affecting the course of illness. Elements of psychosocial rehabilitation are strongly emphasized, including likely difficulties with patient adherence to prescribed treatment. APA practice guidelines relating to patient diagnoses are also discussed
f.	Weekly for one hour while on clinical service (8 hours during PGY4)

405	<b>Consultation Service Clinical Case Conference</b>
a.	Elective (strongly encouraged) PGY1, PGY4 when on consultation and geriatric services
b.	Faculty: Dr. Wain, Ph.D. and Dr. Stasinos, M.D.
c.	Psychology and Psychiatry
d.	Full time
e.	Cases are presented followed by of diagnosis and treatment; selected topics of clinical management and models of consultation. Selected patients may be brought into the conference for “bedside” style teaching relating to interview techniques, psychodynamic formulation and therapy techniques. Approximately half of the patients presented have chronic pain, somatoform, conversion, or dissociative symptoms. Relaxation and hypnosis techniques are discussed in addition to pharmacological and more traditional psychotherapy techniques.
f.	Weekly for one hour (12 hours during PGY4)

406	<b>Dynamic Theory and Selected Topics (continuation from PGY3)</b>
a.	Required PGY4
b.	Faculty: Dr. Waldrep and selected guest faculty
c.	Psychiatry
d.	Full time and part time
e.	Provides an overview of selected topics related to the history of psychiatry, classic articles, and issues not covered in other courses. This is a new course this year – it is being developed to replace a “classic dynamic theory” course that received negative reviews by residents and recent graduates of the program. The new course will include “secondary source” reviews of dynamic theories rather than “primary source” readings. The course will also include elements of community / public sector psychiatry, disaster psychiatry, psychiatric practice under managed care. Guest faculty will include psychiatrists in private practice, HMOs, and state and federal healthcare systems.
f.	Weekly for one hour for 12 sessions (12 hours in PGY4)

407	<b>Evidence Based Medicine</b>
-----	--------------------------------

a.	Required PGY4
b.	Faculty: Drs. Engel and Hoge
c.	Psychiatry
d.	Full time
e.	Provides an overview of the assessment of the psychiatric literature, types of research, statistical analysis, and potential for extension of research findings to clinical practice. Journal articles are reviewed to determine the nature of the research question, methodology, analysis, potential weaknesses / bias, and prospect for generalization of findings. Dr Engel is formally trained and experienced in epidemiological studies and is currently the director or participant in several ongoing multi-site clinical trials. Dr. Hoge is a research director at the Walter Reed Army Institute of Research. Both have published numerous times in peer reviewed journals and serve as research mentors / advisors to residents in the program.
f.	Weekly for one hour for ten weeks (10 hours)

408	<b>Hypnosis Treatment</b>
a.	Required PGY4
b.	Faculty Dr. Wain
c.	Psychology
d.	Full time
e.	Teaches advanced hypnosis concepts for treatment of anxiety and somatic disorders. This is a follow on course to the theoretical hypnosis course provided during PGY3. In this course residents are trained and have the opportunity to practice hypnosis techniques under supervision. Dr. Wain also routinely provides clinical supervision of residents who desire to provide hypnosis treatments in their clinical practice.
f.	Weekly for one or two hours – (5 hours)

409	<b>Social Cultural Psychiatry</b>
a.	Required PGY4
b.	Faculty Dr. Black
c.	Psychiatry
d.	Full time
e.	This course addresses issues of diagnosis and treatment within multiple cultural and ethnic groups found within the United States and abroad. The course specifically covers cultural matters relating to treatment of African American, Multiple Hispanic ethnic groups (Puerto Rico, South America, Filipino), and Asian groups (Korean and Vietnamese) that are representative of the patient population commonly encountered by residents in this program.
f.	Weekly for one hour – (5 hours)

410	<b>Military Psychiatry</b>
a.	Required PGY4
b.	Faculty. Dr. Grieger and invited faculty

c.	Psychiatry
d.	Full time and part time
e.	Residents of this program are expected to be able to function independently as mental health practitioners and managers anywhere in the world following graduation. This seminar addresses issues unique to the practice of psychiatry in a multitude of settings. Topics Include: the organization and mission of mental health services within each military department, psychiatric services in time of warfare, psychiatric aspects of terrorism (including chemical and biological), command consultation and debriefing techniques, psychology of decision-making within groups, organizational culture, aspects of privacy and confidentiality within small commands, managing family member illness in overseas environments, and other selected topics. Readings come from the Textbook of Military Psychiatry volume on War Psychiatry, from federal policy statements regarding the nations international policies, and from articles on management and industrial psychology topics.
f.	Weekly for one hour (23 hours)

411	<b>Sexuality</b>
a.	Required PGY4
b.	Faculty Dr. David Scharff
c.	Psychiatry
d.	Part time
e.	This course discusses issues of sexuality and intimacy from the perspective of object relations theory and provides overview of treatment approaches. Dr. Scharff is a recognized national expert in this field and is the author of multiple articles and books on human sexuality.
f.	Weekly for one hour – (5 hours)

412	<b>Ethics</b>
a.	Required PGY4
b.	Faculty. Drs. Benedek and Howe
c.	Psychiatry
d.	Full time and part time
e.	Reviews basic principles of ethics with special applications for psychiatry. Case vignettes outline common and potentially serious ethical decisions. Dr. Howe sits on several hospital ethics committees and institutional review boards and provides knowledge of ethical principles from a clinical and research perspective. Dr. Benedek is program director of the forensic psychiatry fellowship and provides guidance on ethical issues relating to confidentiality, privacy, and potential tort liability.
f.	Weekly for one hour (4 hours)

413	<b>Geriatric Psychiatry</b>
a.	Required PGY4
b.	Faculty Dr. Grammer
c.	Psychiatry
d.	Full time

e.	Reviews pharmacology and psychotherapeutic issues specific to the elderly population as well as social cultural and access to care matters. Drug-drug interactions, neuronal sensitivity, bioavailability, pharmacodynamic, and pharmacokinetic aspects of aging are specifically covered. Dr. Grammer has completed geriatric psychiatry fellowship training and is faculty on the geriatric service where he provides clinical supervision to residents in that setting.
f.	Weekly for one hour – eight sessions

414	<b>Psychiatry Review</b>
a.	Required PGY4
b.	Faculty Dr. Grammer
c.	Psychiatry
d.	Full time
e.	This course provides an overview of psychiatric assessment, diagnosis, treatment, theories of development, schools of theory, neuroscience, and epidemiology following the Massachusetts General Review of Psychiatry syllabus. This course was developed at the request of recent graduates and residents of the program as a forum for review and consolidation of psychiatric knowledge prior to graduation.
f.	Weekly for one hour – (28 hours)

415	<b>Oral Board Review</b>
a.	Required PGY4
b.	Faculty Drs. Grieger and Benedek
c.	Psychiatry
d.	Full time
e.	Residents are provided an overview of the process and goals of the ABPN oral board examination process. Residents then interview actual patients and provide formulation and case discussion in the format of the ABPN oral examinations – non-interviewing residents observe the interview and presentation from an adjoining observation room. Residents are provided feedback with regard to their conduct of the interview, presentation of the case and proposed treatments. This course serves as a refresher for the principles taught during the clinical case conferences held during PGY3.
f.	Weekly for one hour – (8 hours) (senior residents are also tested individually while on the adult partial hospital / continuity services rotation.)

416	<b>Forensic Psychiatry</b>
a.	Required PGY4
b.	Faculty Dr. Benedek
c.	Psychiatry
d.	Full time

e.	Dr. Benedek is the pgroma director for the forensic fellowship. This course provides training in issues of confidentiality and privacy, duty to protect, competency to stand trial, lack of responsibility assessment, courtroom procedures, and the role of expert versus fact testimony. Dr. Benedek uses text readings and practical examples from his forensic practice and the experiences of his fellows.
f.	Weekly for one hour – (7 hours)

417	<b>Neurology Review</b>
a.	Required PGY4
b.	Faculty Dr. Warden and other neurology staff
c.	Neurology
d.	Part time
e.	This course provides a review of general neurology (anatomy, diagnosis, and treatment of common disorders) using the Clinical Neurology for Psychiatrists text. Since most residents complete their clinical neurology training during PGY1, this course is meant as a refresher and to provide updates in theoretical and clinical aspects of neurology cases likely to be encountered in psychiatric practice. Dr. Warden is board certified and maintains active practice in psychiatry and neurology.
f.	Weekly for one or two hours – (14 hours)

418	<b>Geriatric Service Clinical Conference</b>
a.	Elective, strongly encouraged for PGY4 while on the geriatric service
b.	Faculty Dr. Grammer
c.	Psychiatry
d.	Full time
e.	While on the geriatric service, residents attend a weekly case conference with faculty and the geriatric fellow during their nursing / retirement home clinic day. Programmed readings from a geriatric psychiatry text provide core material which is then applied to the pharmacological and psychosocial treatments of geriatric patients seen in clinic that day
f.	Weekly for one hour (4 hours)

## **SECTION 9. CLINICAL SERVICES**

Provide a brief narrative description of **each** clinical service indicated in the block diagram (see Section 7.0) to include the following information:

- a. Name of service/rotation
- b. PGY year in which clinical experience occurs, whether required or elective, and duration of training
- c. Description of faculty staffing, including discipline and full-time/part-time status
- d. Description of educational methods
- e. Breadth of clinical population and experience, including socioeconomic status, sex, age, ethnic/cultural mix, diagnosis and type of treatment
- f. Average and maximum case loads and description
- g. Scheduled supervision: frequency and whether individual or group
- h. Other (including any other important information relevant to clinical or educational experience).

### **Clinical Service Description:**

- a. ***Name of service/rotation:*** Walter Reed Army Medical Center  
Adult Inpatient Psychiatry Unit
- b. ***PGY year in which clinical experience occurs, whether required or elective, and duration of training:*** Required of PGY-1s for two months. Required of PGY-2s for four months. Required during sub-attending rotation for PGY-4s for three months.
- c. ***Description of faculty staffing, including discipline and full-time/part-time status:*** Three full-time staff psychiatrists are assigned to the 36-bed Adult Inpatient Psychiatry Unit: a Chief of the Service supervises two staff psychiatrists who lead designated treatment teams. Staff psychiatrists have no primary outpatient responsibilities, so are available throughout the course of everyday for any case management questions that may arise. Three staff psychiatrists supervise resident experiences in ECT and neuropsychiatry during their inpatient psychiatry rotation. Treatment team are supported by occupational therapy, activities/recreational therapy, social workers, an art therapists, and a full staff of nurses and psychiatric technicians. There are 1-2 psychology interns, who under supervision of a dedicated staff psychologist conduct all psychological testing. In addition there is a PGY-4 resident who provides clinical and administrative supervision under the direction of the psychiatry faculty
- d. ***Description of educational methods:*** Residents attend protected didactic course time one half-day per week. In addition, residents attend at least four hours of seminars and case conferences on average weekly. The required didactic courses are described for PGY-2s and PGY-4s in detail in Section 4. Assignment of cases to residents is coordinated in general on a rotating admission format, unless the treatment team psychiatrists, the sub-attending PGY-4, and the chief of inpatient psychiatry need to alter the format to ensure that residents evaluate and treat a wide range of psychiatric disorders. The program director monitors patient logs and reports imbalances to the PGY-2 training committee.
- e. ***Breadth of clinical population and experience, including socioeconomic status, sex, age, ethnic/cultural mix, diagnosis and type of treatment:*** There were 2,747 admissions during the past three years, consistently about 900 per year. Patients consist of acute, intermediate, and long-term lengths of stay (minimum 1 day, maximum 178 days, mean 9.65 days SD = 13.12). The patient admissions are comprised of 60.7% men, 39.3% women, 68% Caucasian, 26% African-Americans, 4% Hispanics, and 2% other. The age range is 17 – 86, mean 30.64, SD = 12.10, distribution by age groups: 17-30 61.1%, 31-40 20%, 41-50 11.1%, 51 and older 7.1%. Diagnostic mix is broad. Primary admission diagnoses were depressive disorders 27.7%, substance use disorders (detox) 12.9%, primary psychosis (schizophrenia/schizophreniform) 12.0%, bipolar disorder (10.7%), anxiety disorder 3.6%, cognitive disorder 0.9%, and eating disorder 0.7%. 27.8% received primary admission diagnoses of adjustment disorder or

personality disorder. Most of these had secondary diagnoses of mood disorders, personality disorders (chronic illness) or substance use disorders. Treatment modalities include milieu therapy, psychopharmacotherapy, ECT, group therapy, art therapy, occupational therapy, and recreational therapy. Among pharmacologic treatments, antidepressants comprise 32%, lithium 9%, carbamazepine/valproate 6%, neuroleptics 16%, other 2%. Four percent of patients receive ECT, and 9% get substance detoxification/withdrawal management

- f. *Average and maximum case loads and description:*** PGY-1 residents have an average caseload of 3-4 inpatients, with a cap of five. PGY-2 residents maintain an average of 4-6 inpatients, with a cap of ten inpatients. PGY-4 sub-attending residents provide primary supervision for PGY1 residents under staff supervision. They devote at least half their time to teaching, supervision, and administrative learning on one of the multi-disciplinary treatment teams, comprised of approximately 10-15 inpatients. Patient load and diagnostic mix is carefully monitored to ensure that PGY-1 and PGY-2 residents manage a broad range of patients, of various ages, both genders, and with different psychiatric diagnoses. Residents routinely also evaluate patients for disability/ medical evaluation boards. Under supervision of the staff psychiatrist, the resident is responsible for the examination, diagnosis, and treatment of all patients on the team from their admission to their discharge.
  - g. *Scheduled supervision: frequency and whether individual or group:*** Each patient admitted is personally evaluated by the attending physician and their findings are compared with those entered into the treatment record by the admitting resident. Any differences are discussed with the admitting resident and in some instances the patient may be reevaluated by the attending and resident together to ensure clarification of any differences in observation or interpretation of findings. The inpatient sub-attending PGY-4 receives supervised experience in the clinical or administrative supervision of PGY-1s and PGY-2s. The attending ward psychiatrist spends at least two hours per week with each resident to discuss educational and patient management issues. Daily check-out teaching rounds last one-half hour per day with the staff psychiatrist on call. Staff faculty psychiatrists attend ward meetings such as multi-disciplinary treatment planning conferences. In addition to individual direct supervision, cases are presented in Treatment Planning Conferences, a weekly difficult case conference with outside consultants, and Morning Report.
  - h. *Other (including any other important information relevant to clinical or educational experience):*** Residents are encouraged and supported to attend the abundant scientific meetings and seminars in the Washington DC area at the National Institutes of Health, the Washington School of Psychiatry, and other psychiatric educational institutions. Weekly grand rounds and half-day didactic course attendance is mandatory. Staff attendings cover the unit during didactic time. PGY-1s, and PGY-4s on inpatient psychiatry maintain an ongoing supervised continuity clinic, where they follow some of the patients discharged from the inpatient unit as well as other cases assigned to them early in their training. Average caseload for this clinic is 3 – 4 patients for PGY1; 10 – 12 patients for PGY4.
- 
- a. *Name of service/rotation:*** Northern Virginia Mental Health Institute Inpatient Service
  - b. *PGY year in which clinical experience occurs, whether required or elective, and duration of training:*** Required of PGY2 residents for three months
  - c. *Description of faculty staffing, including discipline and full-time/part-time status:*** The site associate director provides oversight of all resident activities at the facility. Residents are assigned to treatment teams directed by full time board certified psychiatrists. Each team also

has assigned psychologists, activity therapists, psychiatric nurses, social workers and psychiatric technicians.

- d. **Description of educational methods:** In addition to protected didactic course time on half day per week at Walter Reed Army Medical Center, residents attend case conferences, treatment planning conferences, and have individual supervision with staff attending physicians for at least two hours per week.
- e. **Breadth of clinical population and experience, including socioeconomic status, sex, age, ethnic/cultural mix, diagnosis and type of treatment:** There are approximately 1,000 admissions per year to this 126 bed acute and intermediate care facility. The length of stay ranges from one week to several years. The average length of stay is approximately six months. The patient admission are 70% men, 30% women, 49% Caucasian, 28% Black, 11% Hispanic, 10% Asian, and 2% other. Diagnoses: 40% psychotic disorders, 11% depressive disorders, 24% substance use disorders, 10% bipolar disorder, 12% personality disorder, and 3% anxiety disorders. The majority of patients have had multiple hospitalizations and multiple medication trials. Residents conduct extensive admission evaluations on all new patients admitted to their team. Residents manage complex psychopharmacologic treatment, including management of side effects of chronic medication usage (tardive dyskinesia and diabetes). Residents are also trained in psychosocial rehabilitation techniques and are involved in planning for transfer of patients across levels of care within the community. They learn about the process of civilian disability systems and in assisting patients with obtaining appropriate living conditions following discharge from the facility. Many patients are at the facility as a consequence of being found “not guilty by reason of insanity” or not competent to stand trial by the legal system (ranging from 20 – 30% of the inpatient population). Residents are involved in reassessment of these patients in preparation for competency hearings or discharge into the community.
- f. **Average and maximum case loads and description:** Residents typically manage a team of 14 to 20 patients under the supervision of a staff psychiatrist. They generally admit and discharge approximately one patient per week and many of the patients on their team may remain in hospital throughout their three-month rotation at the site.
- g. **Scheduled supervision: frequency and whether individual or group:** Residents attend morning rounds with the attending physician and interdisciplinary staff. In addition, they present all new cases to staff and review all semi-annual treatment summary reports with the attending staff. Individual supervision is at least two hours per week.
- h. **Other (including any other important information relevant to clinical or educational experience):** This clinical rotation provides optimal training in community psychiatry and assessment and treatment of the chronically mentally ill, including psychosocial rehabilitation. As a result of the efforts of patient advocacy groups and involvement of the Justice Department, this facility is modern and better staffed than many private psychiatric hospitals.
- a. **Name of service/rotation:** Adult Psychiatric Partial Hospital / Continuity Services / Community Psychiatry
- b. **PGY year in which clinical experience occurs, whether required or elective, and duration of training:** Required rotation for PGY2 residents for two months and for PGY4 residents for 2 months. PGY1 residents may rotate on the service for one month in lieu of one of their inpatient psychiatry months.

c. **Description of faculty staffing, including discipline and full-time/part-time status:** The assistant program director is the staff psychiatrist assigned to the unit. In addition, the unit is staffed with full time nursing personnel, social workers, activities therapists, and psychiatric technicians. A full time psychologist is available to provide psychological testing of patients on the service. In addition, several civilian consultants are available to provide evaluation and consultation using a case conference model.

d. **Description of educational methods:** All residents attend half day per week protected didactic teaching. They are also encouraged to attend the weekly inpatient complex case management conference and the continuity services case conference. Residents attend the interdisciplinary morning report along with the attending physician. Following morning report they conduct medication rounds under the supervision of the attending physician. All new patients to the program are evaluated by a PGY1 or PGY2 resident and are presented to the PGY4 resident on the team or the staff physician. Patients attending the intensive outpatient program (see below) are also seen in medication rounds and staffed with the attending physician. Because of the high level of acuity in these patients and their recent transfer from an inpatient facility, there is daily individual supervision of residents by staff physicians totaling well over three hours per week.

PGY4 residents spend one day per week at the Montgomery County Crisis center, an urban, community psychiatry service provided by the state of Maryland. In this setting they see “walk in” patients with chronic mental illness and minimal or no available health insurance. Residents evaluate patients for diagnosis and management with supervision by the staff psychiatrist for each presenting case. Management includes safety assessment and stabilization. Patients seen in this setting are then referred for more comprehensive management with a state contracted private agency (systems of care competency).

e. **Breadth of clinical population and experience, including socioeconomic status, sex, age, ethnic/cultural mix, diagnosis and type of treatment:** The patient population closely approximates that of the inpatient psychiatric unit, since the unit provides well over 80% of the referrals to the service. Admissions are comprised of 60.7% men, 39.3% women, 68% Caucasian, 26% African-Americans, 4% Hispanics, and 2% other. The age range is 17 – 86, mean 30.64, SD = 12.10, distribution by age groups: 17-30 61.1%, 31-40 20%, 41-50 11.1%, 51 and older 7.1%. Diagnostic mix is broad. Primary admission diagnoses were depressive disorders 27.7%, substance use disorders (detox) 12.9%, primary psychosis (schizophrenia/schizophreniform) 12.0%, bipolar disorder (10.7%), anxiety disorder 3.6%, cognitive disorder 0.9%, and eating disorder 0.7%. 27.8% received primary admission diagnoses of adjustment disorder or personality disorder. Most of these had secondary diagnoses of mood disorders, personality disorders (chronic illness) or substance use disorders. Patients are initially entered into the program for a planned two week treatment course. This period is increased or decreased based on the patient’s progress and benefit of the program. Selected patients may be enrolled in the intensive outpatient program for up to several months. These patients are seen in medication rounds at least once per week and often several times per week based on current severity of illness and matters of medication adherence or side effects.

PGY4 residents at the crisis center see a broad range of patients in their clinic at the crisis center, ranging from adolescence to the elderly and of any ethnic or cultural mix found in the United States. Frequently seen diagnoses are substance abuse, primary psychotic disorders, and mood disorders with psychotic features. Treatment includes evaluation for safety / need for hospitalization, medication refill, and referral to the chronic care outpatient treatment facility and other community service agencies.

f. **Average and maximum case loads and description:** The average case load for PGY1 and PGY2 residents is four to seven patients. PGY1 residents are capped at six patients and PGY2 residents are capped at 12 patients. PGY4 residents provide supervision for PGY1 and PGY2 residents and also supervise PGY1 residents during their continuity clinic (one half day per week).

During their crisis center clinic day, PGY4 residents see an average of six and a maximum of eight patients per day.

- g. *Scheduled supervision: frequency and whether individual or group:*** Residents receive group supervision approximately five hours per week during morning report and medication rounds and receive daily individual supervision averaging over three hours per week total. PGY4 residents at the crisis center receive one hour of supervision during the day.
- h. *Other (including any other important information relevant to clinical or educational experience):*** This clinical experience provides residents the unique opportunity to follow patients through the full course of illness. They receive patients from the inpatient service (and may have treated the patients while they rotated on the inpatient service), manage their care during the two week transition period, and continue to follow the most seriously ill patients in an intensive outpatient program. The experience they receive at the crisis center builds upon the community psychiatry experience they first gained while working on the inpatient service at Northern Virginia Mental Health Institute and amplifies their understanding of systems based practice in the community.
- a. *Name of service/rotation:*** Consultation Liaison Psychiatry
- b. *PGY year in which clinical experience occurs, whether required or elective, and duration of training:*** Required one month in PGY1 and two months in PGY4
- c. *Description of faculty staffing, including discipline and full-time/part-time status:*** The faculty consists of four full time psychiatrists (two of which have part time duties on the geriatric service and are ABPN certified in geriatric psychiatry or have completed a geriatric fellowship (BE)), one full time psychologist, a full time social worker with extensive addiction training and a full time clinical nurse specialist.
- d. *Description of educational methods:*** PGY1 residents have one half day of protected didactic / continuity clinic time per week. PGY4 residents have one half day protected didactic time per week. Residents attend daily work / teaching rounds in which each new case is presented to the attending physician and examined by that physician with the resident in attendance. In addition to mandatory didactics, the consultation service conducts a weekly case conference in which residents present cases and staff facilitate discussion regarding formulation and treatment. Some patients are brought into the conference for demonstration of interview and treatment techniques. Residents also evaluate patients who are seen in the emergency department (four to five per day on average) and receive direct or indirect staff supervision on these patients. Total individual staff supervision averages 5 hours per week per resident.
- e. *Breadth of clinical population and experience, including socioeconomic status, sex, age, ethnic/cultural mix, diagnosis and type of treatment:*** The service receives consultation on over 1,000 inpatients per year. Gender distribution is nearly equal. Approximately 60% are Caucasian, 20% African American, 10% Hispanic, 8% Asian, and 2% "other". The age range of patients is 18 to 100 with an average age of 55. Diagnoses are somatoform disorder 20%, cognitive disorders or disorders due to a medical condition 20%, mood disorders 20%, anxiety disorders 15%, substance use disorders 10%, transplants 10% and other 5%. Patients are evaluated for recommendations for medication management, diagnostic clarification, outpatient referral recommendations, and recommendations for staff treatment approaches for behaviorally challenging patients. The service also performs competency assessments and safety assessments for patients declining treatment or requesting "against medical advice" discharges. Residents provide supportive, cognitive, and brief dynamic psychotherapy. Up to ten percent of

patients are followed by residents for brief outpatient treatment following discharge from the hospital.

- f. *Average and maximum case loads and description:*** Residents on the service evaluate three to seven new patients per week (maximum ten) and follow approximately five (maximum ten) patients at any given time.
  - g. *Scheduled supervision: frequency and whether individual or group:*** Individual staff supervision is five hours per week (approximately one hour each day) when new patients are staffed and continuing cases reviewed. Group supervision is three hours per week during clinical case rounds and team walk rounds.
  - h. *Other (including any other important information relevant to clinical or educational experience):*** PGY4 residents enhance their teaching and supervisory skills by supervising the work of PGY1 residents and MSIII and MSIV medical students on the service.
- 
- a. *Name of service/rotation:*** Geriatric Psychiatry
  - b. *PGY year in which clinical experience occurs, whether required or elective, and duration of training:*** Required for one month as PGY4, may be an elective for PGY1
  - c. *Description of faculty staffing, including discipline and full-time/part-time status:*** This rotation is staffed by two full time board certified or fellowship trained geriatric psychiatrists, and a part time behavioral neurologist. There is also a full time geriatric psychiatry fellow on the service.
  - d. *Description of educational methods:*** Residents attend a protected half day of scheduled general psychiatry didactic courses per week. There is a one hour conference on general geriatric psychiatry and geriatric pharmacology during the retirement/nursing home clinic day. There is also a clinical case conference tailored to treatment of geriatric patient care one day per week on the consultation service.
  - e. *Breadth of clinical population and experience, including socioeconomic status, sex, age, ethnic/cultural mix, diagnosis and type of treatment:*** During this rotation residents evaluate geriatric psychiatric patients in a variety of clinical settings. They spend one day per week evaluating patients with staff at a local nursing home. Two days per week are dedicated to geriatric hospital consults and geriatric outpatient follow up visits. One morning each week is spent with a behavioral neurologist providing evaluation and behavioral/pharmacological recommendations for patients with severe cognitive disorders. The average age of the clinical population is 75 (range 65 – 95). The population is 60% Caucasian, 25% African American, 10% Hispanic, and 5% Asian. The gender mix is nearly even. Diagnoses are mood and anxiety disorders 50%, cognitive disorders or disorders secondary to a medical condition 35%, psychotic disorders 5%, substance use disorders 5% and other 5%. Treatments include comprehensive evaluation, recommendations for medication adjustment, social and behavioral interventions, family education, and referral to community resources.
  - f. *Average and maximum case loads and description:*** During clinic residents evaluate approximately three new patients per day and see four to five patients in follow up.
  - g. *Scheduled supervision: frequency and whether individual or group:*** All new patients receive direct staff evaluation residents; receive indirect staff supervision for follow up visits. Residents receive a minimum of five hours of individual staff supervision per week. Group

supervision occurs during clinical case conferences and the geriatric clinic symposium/conference. Group supervision averages two hours per week.

- h. Other (including any other important information relevant to clinical or educational experience):** In addition to the two assigned geriatric psychiatrists on the service there is an additional board certified geriatric psychiatrist available for consultation to residents on the general psychiatry consultation service.
- a. Name of service/rotation:** Emergency Psychiatry
- b. PGY year in which clinical experience occurs, whether required or elective, and duration of training:** This is a one month rotation required for PGY2 residents.
- c. Description of faculty staffing, including discipline and full-time/part-time status:** The chief of inpatient psychiatry provides overall supervision of this rotation with the assistance of other inpatient staff attending and senior resident physicians. Staff psychiatrists from all services rotate on the Emergency Psychiatry Service and provide immediate supervision for all cases presenting to the service. Emergency Medicine physicians provide initial evaluation of all patients referred to the Emergency Psychiatry Service and are available for further medical evaluation and to obtain consultation from other specialists based on the findings and recommendations of the Emergency Psychiatry Service resident and staff psychiatrist on duty.
- d. Description of educational methods:** Residents rotate on the service work 12.5 hour shifts five days per week. They receive checkout from a “short call” resident at 8:00 P. M. Sunday night through Thursday night. Their shift ends at the conclusion of morning report and supervision the following morning (generally 8:30 A. M.). The attending physician on-call provides supervision during the shift. All evaluations must be staffed with the attending physician prior to discharge from the emergency department or entry of treatment recommendations into the medical record. All cases evaluated during the shift are also presented during morning report the following day (7:30 A. M to 8:30 A. M.). These forums provides an opportunity for the emergency service resident and staff physician and residents and staff from the inpatient and consult liaison services to discuss matters related to alternative management techniques, systems of practice, and forensic considerations.
- e. Breadth of clinical population and experience, including socioeconomic status, sex, age, ethnic/cultural mix, diagnosis and type of treatment:** Gender, ethnic, and age distributions parallel those of the psychiatry inpatient service: 60.7% men, 39.3% women, 68% Caucasian, 26% African-Americans, 4% Hispanics, and 2% other. The age range is 17 – 86, mean 30.64, SD = 12.10, distribution by age groups: 17-30 61.1%, 31-40 20%, 41-50 11.1%, 51 and older 7.1%. Diagnoses :depressive disorders 27.7%, substance use disorders (detox) 12.9%, primary psychosis (schizophrenia/schizophreniform) 12.0%, bipolar disorder (10.7%), anxiety disorder 3.6%, cognitive disorder 0.9%, and eating disorder 0.7%. While 27.8% received primary admission diagnoses of adjustment disorder or personality disorder, most of these had secondary diagnoses of mood disorders, personality disorders (chronic illness) or substance use disorders. Treatments can include combinations of the following: recommendation for further medical evaluation by the emergency department staff, acute stabilization (using pharmacotherapy and/or psychotherapy techniques), discharge from the emergency department with outpatient follow up, admission to inpatient status, involuntary admission to another hospital for possible commitment, admission to another service based on nature and severity of other health problems, or release with no restrictions.
- f. Average and maximum case loads and description:** Residents on the emergency psychiatry service evaluate between forty and sixty patients during the course of the rotation. They are

responsible for evaluation of all patients presenting to the emergency department with psychiatric complaints, all patients transferred from other hospitals for psychiatric admission, and emergency consults from within the hospital. Residents commonly perform two to four evaluations per shift with a maximum of eight evaluations per shift. During this rotation they have no ongoing continuity clinic or any daytime administrative duties that would create an excessively long work day.

- g. **Scheduled supervision: frequency and whether individual or group:** Residents receive an average of one hour per night of individual supervision discussing evaluation, diagnosis and treatment of each presenting patient with the on-call staff psychiatrist. They also receive five hours of group supervision with the inpatient and consultation service residents at morning report each day.
- h. **Other (including any other important information relevant to clinical or educational experience):** Residents have routinely rated this rotation highly with regard to its usefulness in expanding their knowledge and practice of psychiatry.
- a. **Name of service/rotation:** Adult Outpatient Psychiatry
- b. **PGY year in which clinical experience occurs, whether required or elective, and duration of training:** Rotation required for all PGY3 residents for 12 months and part time for PGY4 residents. Residents are in adult clinic / didactics 4.5 days per week and in child and adolescent clinic for 0.5 days per week during the PGY3 year. PGY4 residents retain a 0.5 day per week adult continuity clinic to complete the full 12 month full time equivalent requirement.
- c. **Description of faculty staffing, including discipline and full-time/part-time status:** Full time psychiatry faculty and part time psychiatry, psychology, social work, and nursing faculty are on site at each of the three adult outpatient clinics (National Naval Medical Center, Walter Reed Army Medical Center, and Malcolm Grow Medical Center). Resident and staff assignments are adjusted to ensure a staff to resident ratio ranging between 1:1 and 1:2 (full time equivalent availability for teaching). In addition to the core teaching faculty, there are approximately 25 part time and full time area psychiatrists who provide psychotherapy supervision between 1 and four hours per week on a volunteer or paid consultant basis. Each resident has an assigned clinical supervisor who oversees all clinical work performed by the resident. Residents then select or are assigned additional faculty supervisors for their required outpatient competencies (e.g., cognitive behavioral therapy, brief dynamic therapy, long term individual, short term group, etc.).
- d. **Description of educational methods:** Residents attend one half day per week of required didactic courses. Having completed the basic psychiatry and human development courses during the PGY2 year, residents now attend classes in cognitive behavioral therapy, dynamic therapy, brief dynamic therapy, family / couples therapy, group therapy, and dynamic theory. The neurosciences curriculum includes modules on pharmacology relating to each major class of psychiatric illness. In addition to didactic courses, each clinic has a weekly clinical case conference with topics that include interview technique, formulation, treatment planning, and practice for the ABPN oral board examinations.
- e. **Breadth of clinical population and experience, including socioeconomic status, sex, age, ethnic/cultural mix, diagnosis and type of treatment:** The population is similar among the three clinics, with a nearly equal distribution of men and women. 75% are Caucasian, 16% African American, 6% Hispanic, 2% Asian, and 1% other. The age range is 17 to 85 with the mean age of 34. 18% of patients are over the age of 60. Diagnoses: 35% depression/dysthymia, 16% anxiety disorder, 16% substance use disorder, 10% personality disorder 11% adjustment disorder, 8% psychotic disorders, 4% other. The majority of patients are treated with combined psychopharmacology, psychotherapy, and environmental interventions. Pharmacotherapy consists of all classes of antidepressants, mood

stabilizers/anticonvulsants, typical and atypical antipsychotics (including patients on clozaril), anxiolytic medications and stimulants. Psychotherapeutic interventions include cognitive treatments, dynamic treatment, family/couple treatments, long term treatments, and group treatments.

- f. **Average and maximum case loads and description:** Each resident's case load is between 30 and 60 patients. Cases are distributed roughly as follows: a) one to three long term individual psychotherapy cases, b) one or two brief dynamic therapy cases, c) one or two cognitive therapy cases, c) one family case, d) one couples case, e) one short term group, f) one long term group. Approximately 50% of the patients receiving psychotherapy treatment from the resident are also prescribed medications by the same resident (combined treatment)
- g. **Scheduled supervision: frequency and whether individual or group:** Residents meet with each global clinical supervisor once per week. Clinical supervisors must review intake evaluations for new patients within 48 hours of the first visit. Records of ongoing care must be signed by staff every three months or every six visits, whichever occurs first. Residents also meet frequently with individual case supervisors (usually at a ratio of treatment hours to supervisory time between one to one and two to one hours). Residents receive approximately six hours of individual supervision per week.
- h. **Other (including any other important information relevant to clinical or educational experience):** PGY4 residents have a 0.5 day outpatient clinic which allows them the opportunity to follow patients continuously for up to two years. Interns also have a 0.5 day outpatient continuity clinic empanelled with patients of lower acuity and shorter duration of treatment. PGY2 residents do not have a continuity clinic panel, but have the opportunity to follow patients during their partial hospital / continuity services rotation.
- a. **Name of service/rotation:** Adolescent Inpatient Psychiatry Unit – National Naval Medical Center
- b. **PGY year in which clinical experience occurs, whether required or elective, and duration of training:** Required for one month during PGY2
- c. **Description of faculty staffing, including discipline and full-time/part-time status:** The staff includes two full time board certified Child and Adolescent Psychiatrists, two full time social workers , three activities therapists, 1 teacher, nurses, technicians, and unit support staff. In addition there is one or two child and adolescent fellow.
- d. **Description of educational methods:** Residents attend protected Wednesday afternoon didactics at Walter Reed. Residents are also scheduled to two supervisory hours with one of the attending physicians. Formal supervision includes interviewing the resident's patients with the attending, case discussion, and review of the literature relevant to particular cases. Additional informal supervision occurs during treatment planning rounds attended by all disciplines. Families are seen with the fellow or with staff psychiatrists or social workers. Techniques of family therapy are reviewed with the social workers. Chart notes are reviewed for form and content.
- e. **Breadth of clinical population and experience, including socioeconomic status, sex, age, ethnic/cultural mix, diagnosis and type of treatment:** The patient population included adolescents from age 13 through 17 and is about 40% males and 60% female. The average length of stay is 21days. Approximately 18% of patients have psychotic disorders, 12% bipolar disorder, 46% mood disorders. The remainder have a variety of disorders, including conduct disorder, eating disorders, and pervasive developmental disorder. The majority of patients have multiple diagnoses, including 30% with co-morbid substance use problems. Patients are treated with antidepressant, antipsychotic, anxiolytic, and mood stabilizing medications. Patients are

provided individual supportive and group interpersonal psychotherapy. Families are engaged in therapy whenever possible.

- f. *Average and maximum case loads and description:*** Residents are assigned one to three patients. Assignments are monitored to ensure that there is an appropriate mix of gender, age, and diagnosis to ensure a variety of educative experience. Over a one month period residents will treat an average of 10 patients and their families.
- g. *Scheduled supervision: frequency and whether individual or group:*** Residents receive at least two hour so individual supervision per week. Additional group supervision occurs during daily work rounds and treatment planning conferences. Residents also receive supervision from social workers before and following family treatment session. Staff psychiatrists are available throughout the day for supervision and questions.
- h. *Other (including any other important information relevant to clinical or educational experience):*** About 20% of patients are received in transport from overseas facilities. This creates an additional challenge for residents and staff as they arrange for follow up care which may include job transfers to parents.
- a. *Name of service/rotation:*** Addictions Service – Malcolm Grow Medical Center
- b. *PGY year in which clinical experience occurs, whether required or elective, and duration of training:*** Required for one month during PGY2
- c. *Description of faculty staffing, including discipline and full-time/part-time status:*** One full time staff psychiatrist who is board certified in psychiatry and internal medicine teaches and supervises residents. The team is also staffed with full time social workers, addiction counselors, recreational therapists, nursing and technical support personnel. Psychological assessment and psychological testing is available from the psychology department.
- d. *Description of educational methods:*** Residents attend protected half day didactics on Wednesday afternoon with includes course work in substance use disorders, detoxification, and pharmacological and psychological treatment of substance use disorders. Residents are assigned programmed readings and meet at least two hours per week with the attending psychiatrist to review the readings and discuss their application to patient in the program.
- e. *Breadth of clinical population and experience, including socioeconomic status, sex, age, ethnic/cultural mix, diagnosis and type of treatment:*** The program is structured as a partial hospital with intensive outpatient treatment available following completion of the program. Most patients attend the partial program for two weeks. Patient with the potential for complicated detoxification are admitted to the inpatient psychiatry unit at Walter Reed or the internal medicine service at Malcolm Grow prior to participation in the program. The attending physician serves as a consultant to the medicine service during detoxification, so residents are able to participate in that aspect of treatment as well. Patient are 65% men, 35% women. The average age of admission is 36 with a range from 18 to 75. 10% of patients are over the age of 60. 65% are Caucasian, 27% African American, 7% Hispanic, and 1% other. The diagnostic mix includes 67% with alcohol use disorders, 9% with cocaine dependence, 9% with benzodiazepine dependence, 4% with opiate dependence, 4% with cannabis abuse, and 6% with other substance use disorders. Co-morbid psychiatric condition include 8% with psychotic disorders, 29% with depression, 22% with anxiety disorders, and 1% with dementia. Treatments include detoxification, pharmacological treatment of psychiatric disorders, individual counseling and education, group therapy, and relapse prevention training. Family assessment and treatment is also available and patient are introduced to 12 step programs including monitored attendance while in the program.

- f. *Average and maximum case loads and description:*** Residents are assigned to a team with 8 – 12 patients in treatment. Assignment of patients to teams is monitored to ensure that each team receives a heterogeneous mix of patient diagnoses, age, and gender. The staff psychiatrist works with each team along with the addictions counselors, social workers, and nursing staff. Residents are responsible for diagnosis, physical examination, management of detoxification and treatment of psychiatric disorders as well as the management or appropriate referral for care of medical problems (present in 50% of patients). Residents are responsible for care from admission to discharge and referral for all psychiatric and medical aftercare for patients on their team.
- g. *Scheduled supervision: frequency and whether individual or group:*** Residents receive two hours of individual supervision per week during which they present new cases to the attending and review treatment plans for other patients on their team. They also review the programmed readings with the staff physician who quizzes them on the materials and basic general information about substance use disorders and their treatment.
- h. *Other (including any other important information relevant to clinical or educational experience):*** In addition to this rotation residents receive experience in detoxification while on the inpatient psychiatry service at Walter Reed and outpatient management of chronic opiate dependence in their clinic at the Montgomery County Crisis Center.
- a. *Name of service/rotation:*** Child and Adolescent Outpatient Psychiatry Clinic – Walter Reed Army Medical Center
- b. *PGY year in which clinical experience occurs, whether required or elective, and duration of training:*** Required of all PGY3 residents 0.5 days per week (1 month FTE)
- c. *Description of faculty staffing, including discipline and full-time/part-time status:*** Faculty consists of three full time and three part time board certified child and adolescent psychiatrists, 2.5 staff psychologists and 2 full time social workers, and one art therapist.
- d. *Description of educational methods:*** Residents attend protected core didactic courses on Wednesday afternoon. This includes a course in child and adolescent development during PGY2 and a course in child and adolescent pathology during PGY3. While in the clinic residents receive extensive direct individual and group supervision. Each new evaluation is directly observed by staff. Each clinic day begins with a group session where residents present their ongoing cases and receive staff guidance on continued evaluation and treatment.
- e. *Breadth of clinical population and experience, including socioeconomic status, sex, age, ethnic/cultural mix, diagnosis and type of treatment:*** The clinical experience includes exposure to pre-school, latency age, and adolescent patients. Diagnoses include 20% ADHD, 5% conduct / oppositional disorders, 35% mood and anxiety disorders, 5% psychotic disorders, 20% developmental disorders, and 15% other (eating disorders, adjustment disorders). Patients are 65% male and 35% female. The ethnic mix is 60% Caucasian, 35 % African American, and 15% other. The majority of patient are between 5 and 17 years of age. Treatments include medications (stimulants, antidepressants, mood stabilizers, and antipsychotics), individual therapy, and family assessment/treatment.
- f. *Average and maximum case loads and description:*** Residents perform at least six comprehensive evaluations (generally involving 6 sessions with the patient and family members). Residents also select a long term treatment case and a family therapy case.

- g. **Scheduled supervision: frequency and whether individual or group:** Residents receive one hour of direct and one hour of individual or group case management supervision per week during the clinic. Family case supervision is scheduled for one hour per week.
- h. **Other (including any other important information relevant to clinical or educational experience):** Treatment of this population provides unique challenges due to frequent absences of a parent due to military operational assignments and frequent geographical moves and changes in providers.
- a. **Name of service/rotation:** Inpatient Neurology
- b. **PGY year in which clinical experience occurs, whether required or elective, and duration of training:** Required for one month during PGY1 (or in PGY4 if not completed during internship)
- c. **Description of faculty staffing, including discipline and full-time/part-time status:** The neurology inpatient service is staffed with a full time staff neurologist, a senior neurology resident, and has available subspecialists in seizure disorders, movement disorders, neuromuscular disorders, neurophysiology, and neuroimaging. The service has 24 hour access to EEG, evoked potential, nerve conduction studies, CT, MRI, functional MRI, sleep study laboratory, and nuclear medicine studies.
- d. **Description of educational methods:** As a PGY1 the resident works on a team with the senior resident, a junior neurology resident, another intern and medical students, all under the supervision of the staff neurologist. The PGY1 resident performs admission histories and physical examination which is either directly observed or repeated by the senior resident or staff member. Cases are discussed at the time of admission with regard to differential diagnosis and treatment approach. The team meets with the attending for at least one hour per day to discuss and examine new patients and to discuss management of patients previously admitted. In addition, the neurology service holds a two hour case conference each week in which patients are presented and examined. Subspecialists present reviews of the nature and treatment of the disorders presented.
- e. **Breadth of clinical population and experience, including socioeconomic status, sex, age, ethnic/cultural mix, diagnosis and type of treatment:** Patient age ranges are from 6 months (consults from the pediatric service) to 95. Disorders include newly presenting multiple sclerosis, stroke, demyelinating disorders, dementing disorders, disorders of metabolism or neural development, and seizure disorders. Ethnicity approximates that of the general population of the United States and gender is nearly equal for men and women. Patient receive comprehensive evaluation including neuroimaging, EEG, evoked potential, nerve conduction studies, sleep studies, and 24 hour videomonitoring for seizure disorders. Treatments include use of anticonvulsants, thrombolysis of thrombotic strokes, steroid treatments, alpha interferon treatment and other complex medication regimens. Patients are also referred to occupational medicine, rehabilitative medicine, and speech therapy as appropriate.
- f. **Average and maximum case loads and description:** The inpatient team manages between 7 and 12 patients on average, with an average length of stay of 9 days and one admission per day.
- g. **Scheduled supervision: frequency and whether individual or group:** Residents receive one hour of supervision for each new admission and one hour per day of group supervision per day during attending rounds.
- h. **Other (including any other important information relevant to clinical or educational experience):** The neurology service is a world wide catchment center for complex neurology cases. Residents on this service see both common extremely complex neurologic cases.

- a. **Name of service/rotation:** Outpatient Neurology
  - b. **PGY year in which clinical experience occurs, whether required or elective, and duration of training:** Required for one month during PGY1 (PGY4 for residents not completing the requirement during PGY1)
  - c. **Description of faculty staffing, including discipline and full-time/part-time status:** The outpatient neurology staff includes five full time neurologists, EMG and evoked potential technicians, and nursing staff. PGY1 residents assigned to the service work under the direct supervision of a senior neurology resident and the indirect supervision of the staff neurologist assigned to the clinic that day.
  - d. **Description of educational methods:** Residents evaluate 1 – 4 patients per day in clinic of in consultation to an inpatient service. Residents collect the history and perform a physical examination and then present the case to the senior resident who discusses the possible diagnoses and treatment. Cases are staffed with the attending neurologist at the end of the day (or at the time of evaluation if there are uncertainties about the case). In addition the service conducts a 2 hour teaching conference weekly in which basic aspects of anatomy, diagnosis and pathophysiology of common neurological disorders are discussed.
  - e. **Breadth of clinical population and experience, including socioeconomic status, sex, age, ethnic/cultural mix, diagnosis and type of treatment:** Patients in this clinic present with common, less severe, or stable disorders. Typically patients are seen for headaches, and for follow up of MS, stroke, demyelinating disorders, seizure disorders, and peripheral neuropathies. The average age is 46 with ages ranging from 18 to 95. The ethnicity closely resembles that of the United States and the mix of males and females is nearly equal. Patients receive interim history and physical examination. They may be referred for diagnostic testing or be seen in follow up to review findings of studies. Treatments include medications for migraine (acute or prophylactic), adjustment of seizure medication, treatment of MS, and treatment of neuropathic pain.
  - f. **Average and maximum case loads and description:** Residents see 1 – 4 patient per day (approximately 50 patients during the rotation)
  - g. **Scheduled supervision: frequency and whether individual or group:** Residents receive supervision for each patient seen. They discuss the history and findings with the senior resident who may assign readings related to further understanding of the disorder. This case based supervision is usually one hour per day. In addition, the PGY1 and the senior neurology resident meet for one hour per day with the staff neurologist to further discuss patients seen in clinic that day.
  - h. **Other (including any other important information relevant to clinical or educational experience):** This rotation is intended to provide psychiatry residents with exposure to assessment of common neurological disorders they will likely encounter in their routine practice.
- 
- a. **Name of service/rotation:** General Internal Medicine Inpatient Service
  - b. **PGY year in which clinical experience occurs, whether required or elective, and duration of training:** Required PGY1 for 2 months
  - c. **Description of faculty staffing, including discipline and full-time/part-time status:** Walter Reed Army Medical Center and the National Naval Medical Center both have ACGME approved

residencies in internal medicine and medicine subspecialties. Each inpatient team is staffed with a board certified staff physician, a senior medicine resident, a junior medicine resident and two interns (one of which is the psychiatry PGY1 resident). Each hospital is equipped with state of the art laboratory, imaging, operating rooms, intensive care units, and interventional treatment equipment. Each hospital has full time nursing and technical staff as well as phlebotomy services.

- d. *Description of educational methods:*** The resident is directly supervised by the junior and senior internal medicine residents. Psychiatry residents perform histories and physical examination on patients assigned to them. Internal medicine residents provide instruction on aspects of patient care, including cognitive knowledge and technical skills. On ward rounds the attending physicians teach principles of diagnosis and treatment by discussing individual cases. Attending rounds are held four times per week. The Department of Medicine holds medicine grand rounds and a clinical case conference one per week.
  - e. *Breadth of clinical population and experience, including socioeconomic status, sex, age, ethnic/cultural mix, diagnosis and type of treatment:*** The clinical population includes a wide diversity of ethnic groups which approximates the ethnic distribution of the population of the United States. Average age of patient is 55 with a range from 18 to 95. Disorders include cardiac, pulmonary, GI, renal, metabolic, neoplastic, and infectious disorders. Patients admitted to the service are severely ill and often are approaching system failure at the time of admission. The average length of stay is 7 days. Patients receive comprehensive evaluation, diagnostic studies, referral for subspecialty evaluation, acute stabilization and medications.
  - f. *Average and maximum case loads and description:*** PGY1 residents are assigned 5 – 9 patients with acute and chronic illnesses and multiple medical problems.
  - g. *Scheduled supervision: frequency and whether individual or group:*** Medicine residents provide direct supervision on all cases admitted and whenever the PGY1 requests assistance. In addition, the attending physician rounds with the team four times per week for group supervision. Subspecialists are available for consultation and provide face-to-face recommendations to residents with the opportunity to obtain clarification.
  - h. *Other (including any other important information relevant to clinical or educational experience):*** The internal medicine service has ACGME approved fellowships in cardiology, critical care medicine, nephrology, pulmonology, gastroenterology, rheumatology, oncology, and infectious disease.
- 
- a. *Name of service/rotation:*** Medical Intensive Care Unit
  - b. *PGY year in which clinical experience occurs, whether required or elective, and duration of training:*** Required for one month in PGY1
  - c. *Description of faculty staffing, including discipline and full-time/part-time status:*** The clinical faculty is board certified in general internal medicine and critical care medicine. A critical care fellow, senior internal medicine resident and a junior internal medicine resident are assigned to the unit in addition to other PGY1 residents from other specialties.
  - d. *Description of educational methods:*** The intern is directly supervised by the resident and critical care fellow who provide instruction on aspects of patient care, including cognitive knowledge and technical skills. On ward rounds the attending physicians teach principles of diagnosis and treatment by discussing individual cases. Attending rounds are held daily. The Department of Medicine holds medicine grand rounds and a clinical case conference one per week.

- e. **Breadth of clinical population and experience, including socioeconomic status, sex, age, ethnic/cultural mix, diagnosis and type of treatment:** The clinical population includes a wide diversity of ethnic groups which approximates the ethnic distribution of the population of the United States. Average age of patient is 55 with a range from 18 to 95. Disorders include cardiac, pulmonary, GI, renal, metabolic, neoplastic, and infectious disorders. Patients admitted to the service are severely ill and often are often in multi-system failure at the time of admission. The average length of stay is 7 days. Patients receive comprehensive evaluation, diagnostic studies, referral for subspecialty evaluation, acute stabilization and medications.
  - f. **Average and maximum case loads and description:** The PGY1 resident is assigned 1 – 3 critically ill patients, many of whom are in multi-system organ failure and require complex life support equipment.
  - g. **Scheduled supervision: frequency and whether individual or group:** Residents have individual supervision as well as “work rounds” supervision daily. Attending rounds occur daily. Supervision is provided by the attending physician, critical care fellow, and the medicine resident.
  - h. **Other (including any other important information relevant to clinical or educational experience):** The internal medicine service has ACGME approved fellowships in cardiology, critical care medicine, nephrology, pulmonology, gastroenterology, rheumatology, oncology, and infectious disease. The intensive care units provide a unique opportunity for psychiatry residents to work with the most severely ill patients and their families, many who are facing the prospect of death.
- 
- a. **Name of service/rotation:** Ambulatory Medicine
  - b. **PGY year in which clinical experience occurs, whether required or elective, and duration of training:** Required one month for PGY1 and additional time may be spent as an elective
  - c. **Description of faculty staffing, including discipline and full-time/part-time status:** Attending physicians board certified in general internal medicine and subspecialties are assigned to the clinic.
  - d. **Description of educational methods:** Residents attend medicine morning report, noon lecture, and grand rounds. In addition they present all cases to their assigned preceptor upon completion of their evaluation.
  - e. **Breadth of clinical population and experience, including socioeconomic status, sex, age, ethnic/cultural mix, diagnosis and type of treatment:** The average age of the population is 61 years. The gender mix is nearly equal. Ethnicity approximates that of the United States. Patient have a variety of medical conditions, chronic and acute, and most are on multiple medications. Patient receive a comprehensive evaluation, appropriate laboratory or other studies, treatment with medication and referral to subspecialists if appropriate.
  - f. **Average and maximum case loads and description:** Residents see one new patient and four follow up patients per day. Patients may need laboratory work or review of laboratory findings, medication refill or adjustment of medications and may need for referral to other specialties as part of their treatment.

- g. *Scheduled supervision: frequency and whether individual or group:*** Precepting attending physicians provide individual supervision for each patient seen in clinic (an average on one hour per day)
  - h. *Other (including any other important information relevant to clinical or educational experience):*** This rotation is intended to provide residents with confidence in managing routine medical problems they may encounter in their practice and knowledge of when to refer to specialists for more comprehensive evaluation.
- 
- a. *Name of service/rotation:*** Emergency Medicine
  - b. *PGY year in which clinical experience occurs, whether required or elective, and duration of training:*** Required for one month for PGY1
  - c. *Description of faculty staffing, including discipline and full-time/part-time status:*** Five board certified emergency medicine physicians and a full staff of nurses and technicians.
  - d. *Description of educational methods:*** The resident discussed each patient with the staff physician. Pertinent aspects of differential diagnosis, treatment, and disposition are discussed. Clinical conferences are held at shift change, at which the faculty discuss selected topics in Emergency Medicine, as well as instructive cases seen during the preceding 24 hours.
  - e. *Breadth of clinical population and experience, including socioeconomic status, sex, age, ethnic/cultural mix, diagnosis and type of treatment:*** The patient population includes both genders, a full range of ages, and diverse ethnic and cultural backgrounds. Patients present with diverse medical and surgical problems, including chest pain, complications of pregnancy, abdominal pain, fevers, infections, and minor injuries. They receive rapid and accurate diagnosis, acute treatment, and referral for follow up care.
  - f. *Average and maximum case loads and description:*** The resident will evaluate 25 – 30 patients per twelve hour shift
  - g. *Scheduled supervision: frequency and whether individual or group:*** The resident presents each patient to the attending physician before initiating treatment or disposition. The attending may elect to personally examine the patient and demonstrate aspects of physical examination of treatment to the resident at bedside. Supervision is individual and amount to approximately one hour per twelve-hour shift.
  - h. *Other (including any other important information relevant to clinical or educational experience):*** The goal of this rotation is to provide the resident with experience in managing acute complaints which they will likely encounter in the clinical practice and to know when to refer for specialty care and evaluation.

## **MILITARY EVALUATIONS:**

As Military Officers you will receive annual reports of your military performance. While these may also reflect your academic performance, there are components that fall outside that realm. **Each hospital is responsible for establishing the system of evaluation for its officers.** While the site training director may be the one assigned this important task, the number of residents in a military branch may require additional assistance from other members of that department. Raters can evaluate you accurately only if

you submit a comprehensive listing of your accomplishments. You are strongly encouraged to draft the narrative of your evaluation as a means to this end and as practice for your future role as a military supervisor.

## **DUE PROCESS**

Rarely, serious problems threaten the completion of the resident's training. For these cases a set of Due Process Procedures has been defined by the National Capital Consortium for Military Medical Education. A full copy of these procedures is outlined in the National Capital Consortium Administrative Handbook. A copy of the Handbook is available in the education office (Room 2061 Building 6 – Borden Pavilion – Walter Reed Army Medical Center) and can be viewed and printed from site <http://www.usuhs/mil/gme/NCC.htm>. Due process procedures are summarized below.

If a supervisor identifies problems of resident performance, the supervisor will inform the resident of the problems and action needed to correct them. Should the problems persist, the supervisor will notify the resident that the matter will be taken to the PGY training committee or policy committee for review. The resident may elect to attend the meeting at which the problem is discussed, may have another resident represent them, or may represent themselves and have another resident in attendance. Usually the outcome of such meetings is the development of a non-formal or formal course of remediation. In the event that the problems are not resolved, more formal action may be necessary.

Training status may be restricted, suspended or terminated if the program director receives information that indicates that significant improper, unethical or unprofessional conduct by the resident has occurred that is likely to adversely affect his or her ability to engage in patient care activities. Training may also be restricted or suspended if the resident develops significant health problems, faces administrative or legal action that prevents continued training, or cannot meet training objectives after significant remediation efforts have been attempted. Remediation efforts may include supplementary supervision, extension of training, or academic probation.

A written notification and record-keeping procedure protects the rights of both the resident and the program as all efforts are made to allow residents to meet goals and objectives of training prior to restriction, suspension, or termination of training status. In addition, a structure is in place within the NCA Military Education Consortium to allow residents whose training has been restricted, suspended, or terminated to appeal or contest these actions. This right is afforded by a formal hearing before a consortium GME committee, including the right to counsel.

## **FACULTY AND PROGRAM EVALUATION**

There is a written record of the qualifications and educational responsibilities of all staff and faculty who participate in the clinical training and education of residents. Faculty qualifications are kept in a centralized record location by the program director. In addition, medical center clinical departments and credentials offices maintain credentials folders on all providers. All consultants are required to be credentialed and privileged by at least one of the participating medical centers.

The program values very highly resident evaluation of faculty performance involving both clinical and didactic teaching. Upon completion of a course or at the end of a semester (at least once per year per course), evaluation forms are completed by all residents. These are made part of a permanent record for all faculty members. Written and oral feedback is given at least yearly to all course faculty and supervisors.

The Residency Training Committee has a mechanism in place to continually evaluate the residency program as a whole. At least twice a year the site and program directors meet formally with each resident class to obtain feedback on the program. More frequent informal meetings are also held. The program director meets weekly with the program housestaff president. Both overall and specific didactic and clinical issues are reviewed at least once each year in all-day faculty retreats. Both faculty and residents attend these conferences. Specific didactic issues and clinical issues are referred to the Policy Committee. The policy committee also reviews closely the results of the PRITE and mock board examinations.

## **PATIENT LOG BOOKS**

Each resident is required to keep a permanent record of certain data about all patients that they work with during their psychiatric training. Several different logs exist. You may use any method or format that you wish, as long as the necessary information is listed. Twice yearly you will be required to submit hard copy of patient profiles that include age, sex, diagnosis, and treatment modalities for review by the site training director or program director. These profiles will become a permanent part of your training record. The site training director reviews the log and ensures balance in case distribution. In keeping your patient log, and in handling the readouts from your log, do everything necessary to preserve the privacy of the patients involved.

Attachment G. Blank Sample Patient Log Page (Excel)

Patient ID	Gender	Age	Dates	Primary DX	Setting	Treatments

## **Resident Duty Hours and the Working Environment**

Providing residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energies. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

### **1. Supervision of Residents**

- a. All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.
- b. Faculty schedules must be structured to provide residents with continuous supervision and consultation.

- c. Faculty and residents must be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects.

## 2. Duty Hours

- a. Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.
- b. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
- c. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a four week period, inclusive of call. One day is defined as one continuous 24- hour period free from all clinical, educational, and administrative activities.
- d. A-10 hour time period for rest and personal activities must be provided between all daily duty periods, and after in-house call.

## 3. On-Call Activities

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24 hour period. In-house call is defined as those duty hours beyond the normal work day when residents are required to be immediately available in the assigned institution.

- a. In-house call must occur no more frequently than every third night, averaged over a four-week period.
  - b. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, maintain continuity of medical and surgical care, transfer care of patients, or conduct outpatient continuity clinics.
  - c. No new patients may be accepted after 24 hours of continuous duty, except in outpatient continuity clinics. A new patient is defined as any patient for whom the resident has not previously provided care.
  - d. At-home call (pager call) is defined as call taken from outside the assigned institution.
- 1.) The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.
  - 2.) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.
  - 3.) The program director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

## 4. Moonlighting

- a. Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program. **Moonlighting is prohibited in this program**

## 5. Oversight

- a. Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment. These policies must be distributed to the residents and the faculty. Monitoring of duty hours is required with frequency sufficient to ensure an appropriate balance between education and service.
- b. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.

## CALL POLICY

### General Call Eligibility

#### Interns

Psychiatry PGY-1 residents are eligible for call during the following rotations: inpatient psychiatry, PCLS, and outpatient neurology, except for approved leave or TAD (e.g. C4 course).

Navy transitional and internal medicine PGY-1 residents are eligible for call during the entirety of their psychiatry and/or psychiatry/neurology rotations except for approved leave or TAD (e.g. C4 course).

Categorical PGY2 - 4 psychiatry residents are eligible for call during all rotations, including electives, except:

- Away rotations with prior approval of the Program Training Director.

- The final rotation of the PGY-4 year if moving out of the local area.

Combined (FP or IM) psychiatry PGY 2-5 residents are eligible for call during all psychiatry rotations, including psychiatry electives, except:

- Away rotations with prior approval of the Program Training Director.

- The final rotation of the combined PGY-5 year if moving out of the local area.

Any conflicts with family practice or internal medicine residency requirements. Call scheduling must be coordinated between the CPR president, the family practice/psychiatry chief resident, and the internal medicine/psychiatry chief resident to avoid any conflicts.

### General Call Frequency

All residents eligible for call will be assigned a minimum of 2 calls per four-week rotation.

For categorical psychiatry residents, the maximum number of calls assigned per year group is as follows:

- PGY-1: 7 calls per four-week rotation.

- PGY-2: 5 calls per four-week rotation.

- PGY-3: 4 calls per four-week rotation.

- PGY-4: 3 calls per four-week rotation.

For combined (FP or IM) psychiatry residents the maximum number of calls assigned per year group is as follows:

- PGY-1: 7 calls per four-week rotation.

- PGY-2: 5 calls per four-week rotation.

- PGY-3: 4 calls per four-week rotation.

- PGY-4: 3 calls per four-week rotation.

PGY-5: 3 calls per four-week rotation.

No back-to-back calls – No call shall be assigned within 24 hours of another assigned call for the same resident unless approved by the Training Program Director and the assigned resident.

Call-free weekend – Each resident must have at least one call-free weekend (Friday-Sunday) per four-week rotation.

### **Clinical Duty Following Call.**

In House Call: All residents who take call in-house call (including interns on any service) are excused of all clinical duties at noon on the day following call. Residents may provide follow up care to patients know to them between 0600 and 1200 on the day following call, but may not see any patients that are new to them (not previously personally evaluated or treated by that resident). Any resident who is requested by staff or a senior resident to continue in clinical duties beyond noon of the day following call is to notify the program director or site associate director and provide the name and pager of the physician making the request.

At Home Call: Residents taking call from home may occasionally be involved in clinical duties through much of the night. In order to ensure that they do not exceed the duty hour limitations, residents on outpatient clinical rotations shall schedule no new patients for the morning following call and no patients after noon on the day following call.

Pyramidal structure of call assignment

Does not apply to PGY-1 or PGY-2 residents who are limited to call at WRAMC.

Residents may be assigned a number of calls equal to but not exceeding residents from a more junior year group in any given rotation.

### **Types of Psychiatry Resident Call**

Resident responsibilities for each call assignment are outlined in the psychiatry call policy for each specific hospital.

#### **WRAMC**

Intern

In-house.

Typically assigned to PGY-1, but may be covered by any PGY 1-5 resident.

On a case-by-case basis, the WRAMC intern position may be left unassigned. In this event, the WRAMC POD will be expected to cover intern duties, but may solicit help as necessary through the CPR president.

Resident – POD

In-house.

Typically assigned to a PGY-2, but may be covered by any PGY 2-5 resident.

Types of call

Short Float: 1600-2000, Monday – Thursday

Weekends

Friday: 1600 – 0830

Saturday: 0800 – 0830

Sundays: 0800 – 2000

#### **NNMC – POD**

Home-call.

Typically assigned to a PGY-3 resident, but may also be covered by a PGY-4 or a PGY-5 resident.

### **MGMC – POD**

Home-call.

Must be a PGY-3 or more senior resident who has completed the categorical PGY-2 year residency requirements.

### **Generation of Call Assignments for each Rotation Block**

Call Conflicts and Requests – At least two weeks prior to each block, the call committee will provide a forum for all the psychiatry residents to communicate any call conflicts or call requests. It is the responsibility of each resident eligible for call to communicate these issues to the call committee in the provided forum. Conflicts or requests not communicated in this forum will be the responsibility of the assigned resident to arrange coverage if call is assigned on those days.

Call Conflicts – any time period when a resident cannot be required to take call. Examples include: Approved leave, Approved TAD/TDY (including C4 and Bushmaster).

Call Requests – any time period when a resident may be assigned call, but would ideally be avoided due to other obligations. Examples include: Weekly clinic. Weekly group sessions, Training psychotherapy, Significant personal obligations.

Guidelines for Call Assignments – These are goals and not requirements for call assignment.

Every effort should be made to ensure that call assignments are as evenly distributed among individuals as possible. This may be accomplished via month-to-month record keeping, according to the quarterly cumulative report, or at the discretion of the Call Committee.

Call should be distributed such that each individual resident is free of call within 48 hours of another call assignment.

For every two calls assigned, one should be on a weekday (Monday through Thursday), and one should be on a weekend (Friday through Sunday).

PGY-4 and PGY-5 residents are assigned call only at MGMC.

Combined FP/Psychiatry residents during their year of outpatient psychiatry are assigned NNMC call on Saturdays whenever possible, unless they request otherwise.

Combined residents (FP or IM) during the PGY-5 year are assigned call only during weekdays at MGMC (Monday – Thursday).

#### **Call Schedule Publication**

A draft of each call schedule will be provided to the Program Training Director, the CPR President, all the CPR Vice Presidents, and the entire call committee at least 72 hours before the final schedule is published.

The CPR president or his/her designee(s) must give approval prior to the publication of the final call schedule.

The final call schedule will be published to all members of the NCC psychiatry residency, the Program Training Director, and all three area hospitals at least one week prior to each rotation block.

### **Call Changes**

Each resident is responsible for covering his/her assigned call according to the final call schedule published each month by the Call Committee. Call coverage includes:

The assigned resident standing his/her assigned call.

The assigned resident arranging for an appropriately qualified (licensed, hospital requirements met) resident(s) to stand the entire call in place of the assigned resident.

Call Switches – The resident must notify the entire residency and the appropriate hospital of each call switch prior to the start of the assigned call. MGMC Call changes require “in-person” notification of the ED. Residents must provide MGMC psychiatry staff with enough advanced notice that this can be accomplished before the period of call.

Alterations in the call schedule after publication of the final call schedule – The CPR president or his/her designee(s) may change the final call schedule as needed by notifying the entire residency, the Program Training Director, and the appropriate hospital no later than 24 hours before any changed call assignments.

### **Go-to List**

Definition – The Go-to list is a list of psychiatric residents maintained by the CPR president as a resource for call coverage in the event that any resident is unable to stand his/her assigned call and is unable to arrange for appropriate coverage.

#### **Composition**

All PGY 2-5 categorical and combined psychiatry residents.

PGY-1 residents and child fellows are not included on the Go-to list.

#### **Compilation and Distribution**

All new PGY-2 categorical and combined psychiatry residents will each be randomly assigned one place on the top of the Go-to list at the beginning of each academic year.

All graduating residents will be removed from the Go-to list at the end of each academic year.

An updated Go-To List will be made available to all residents at the beginning of each academic year and after every activation.

#### **Implementation**

The Go-to list will be activated by the CPR president or his/her designee in the event the assigned resident is unable to stand call and is unable to arrange for call coverage.

Beginning with the top of the Go-to list and descending in order, each resident qualified to stand call at the assigned hospital who has neither stood call within 48 hours nor is scheduled to stand call within 48 hours will be contacted.

Any qualified eligible resident who is contacted for activation of the Go-to list is obligated to stand the emergency call.

At no time will a hospital be without someone to cover call duties. If necessary, coverage during the interim between change-of-watch and arrival of the “goated” resident will generally be provided by another resident at staff’s discretion.

#### **Altering the Go-to list after an activation**

At the discretion of the CPR president, the resident unable to stand his/her assigned call may be placed at the top of the Go-to list for each missed call.

Any resident with his/her name on the Go-to list more than once, who is activated to stand emergency call, will have his/her name removed once from the highest spot on the Go-to list.

Any resident whose name appears once on the Go-to list and who is activated to stand emergency call will have his/her name moved to the bottom of the Go-to list.

### **Tabulations of Call Duty**

The Call Committee will maintain a record of all call assignments during the current academic year.

At least once a year, the Call Committee will report to the CPR on the year’s cumulative call totals.

#### **Call tabulations**

Short Float calls at WRAMC (see above) will be counted as half a regular call in the tabulations of call duty.

All other call assignments regardless of the call duration or location will be counted as one full call in the tabulations of call duty.

### **Holiday Call**

At the beginning of each academic year, the Call Committee will create a call schedule for all federal holidays and the contiguous weekends for the entire academic year. Site-specific training holidays

will not be considered for holiday call assignment. Applies only to PGY 2-5 categorical and combined psychiatry residents.

Holiday Requests - the call committee will provide a forum for all the psychiatry residents to communicate any holiday call conflicts or holiday call requests at the beginning of the academic year.

Call Conflicts – any time period when a resident cannot be required to take holiday call. Examples include: Approved leave, Approved TAD (including C4 and Bushmaster). Emergency Psychiatry rotation, Any conflicts with Family Practice or Internal Medicine residency requirements, Away rotations with prior approval of the Program Training Director.

Call Requests – any time period when a resident may be assigned holiday call, but would ideally be avoided due to significant personal obligations.

Pyramidal structure – PGY 4-5 residents may be assigned a number of holiday calls equal to but not exceeding PGY-3 residents.

Combined Residents (FP and IM) will be assigned a number of holiday calls proportionate to the number of psychiatry rotations they will have during the academic year. For example, a combined resident who has psychiatry rotations for only half the academic year will have approximately half as many holiday calls assigned as a psychiatry resident from the same year group who has psychiatry rotations for the entire academic year.

Holiday call assignment should be as evenly distributed among individuals as possible.

The drafting, approving, publishing, and altering of each year's holiday call schedule will follow the same policy as any rotation block call schedule as outlined above.

Emergency Psychiatry rotation – the resident assigned to night float will not be assigned call the night before a holiday period, but will be assigned call on the last night of a holiday period. For example: Over a 3-day (Saturday – Monday) holiday – The night float is off from Friday - Sunday, but will be assigned call as usual Monday night, Over Thanksgiving – The night float is off from Wednesday - Saturday, but will be assigned call as usual on Sunday night.

#### Break-in Call Assignments

Beginning with rotation block 1, each psychiatry PGY-2 resident will be assigned 1 “break-in” call at WRAMC, and each PGY 3 resident will be assigned 1 “break-in” call at NNMC.

#### Requirements

All residents must receive one break-in call at WRAMC, and those who have not completed a PGY 2 adolescent rotation at NNMC must receive one NNMC break-in call. A short float break-in call at WRAMC counts as half a call and necessitates another half of a break-in call to fulfill the break-in requirement.

Resident responsibilities for each break-in call assignment are outlined in the standard operating procedure of psychiatry call for WRAMC.

PRITE Coverage – During the annual PRITE administration, every resident will be afforded a call-free night prior to his/her examination(s). Make-up dates will be arranged for those residents required to stand call on the nights prior to the examination(s).

Residents have, on average, at least one day in seven free of hospital duties at each level of training.

When a resident is on call, a faculty psychiatrist is always available for consultation and assistance if needed.

## **RESIDENT CALL COMMITTEE**

### **PURPOSE**

The Call Committee is a group of psychiatry residents tasked by the Council of Psychiatric Residents (CPR) to oversee the scheduling of all psychiatry call assignments. The committee functions under the authority of the residency Policy Committee.

### **GOALS**

The call committee's primary goal is to work in conjunction with the CPR leadership to provide the CPR membership and affiliated training hospitals a call schedule in a timely fashion. It is the aim of the committee to distribute call assignments as evenly as possible within the framework of the NCCMPR Policy for the Assignment of Call.

### **MEMBERSHIP**

#### **Composition**

The call committee is composed of up to five voting members of the CPR. There must be at least one representative from the PGY-2 year group on the Call Committee.

#### **Appointments**

The CPR leadership (the CPR president and the vice presidents) will appoint new members to the call committee annually before the start of each academic year.

The CPR leadership may also appoint new call committee members as needed to fill vacancies on the committee through out the academic year.

#### **Length of Service**

1-year commitment - Members on the committee are expected to complete at least one year of service on the Call Committee.

Extensions - One, two, and three-year extensions of service are encouraged to promote continuity on the committee as long as space is available for a new PGY-2 representative each academic year.

#### **Termination**

Any member of the call committee may resign from the committee at any time by notifying the CPR leadership.

The CPR leadership may revoke the appointment of any call committee member at any time.

#### **Chairperson**

The CPR leadership will appoint a Call Committee Chairperson to a one-year term of service.

The chairperson is a member of the committee and has executive responsibility for the operation of the committee and for implementation of the Standard Operating Procedure.

The CPR leadership may revoke the appointment of the call committee chairperson at any time.

### **RESPONSIBILITIES**

Generate and publish the monthly psychiatry resident call schedule

Generate and publish the annual resident holiday call schedule

Generate and publish cumulative call totals at least once a year

Schedule break-in call for eligible residents as required by the training program

Report at the weekly meeting of the CPR membership

## **OUTSIDE ACTIVITIES**

Residents are not allowed to engage in activities that interfere with education, performance, or clinical responsibility. Residents are not allowed to "moonlight." Military officer salaries and benefits are very generous, far exceeding the civilian average, making outside employment unnecessary. Attendance at outside academic activities is encouraged but must be approved by the Officer in Charge of the service to which the resident is currently assigned, the site training director, and by the Program Director.

## **FINANCIAL COMPENSATION**

All residents in the program are Commissioned Medical Officers in the Uniformed Services of the United States. Financial compensation of Medical Officers depends on rank, length of service, and any special or incentive pays to which the individual Officer may be entitled. Benefits apart from salary include health insurance for the member and his or her family, liability insurance, tax-free allowances for quarters and food, commissary privileges, paid sick leave, and exchange privileges.

## **LIABILITY COVERAGE**

Residents are provided with professional liability coverage related to their clinical activities in the program by U.S. Statutes that protect military physicians. This protection is effective for actions initiated after the resident has left the program. The following is an abstract from Public Law 94-464, "An Act To provide for an exclusive remedy against the United States in suits based upon medical malpractice on the part of medical personnel of the armed forces....."

"(a) The remedy against the United States provided by sections 1346(b) and 2672 of title 28 for damages for personal injury, including death, caused by the negligent or wrongful act or omission of any physician of the armed forces, in the performance of medical, dental or related health care functions (including clinical studies and investigations) while acting within the scope of his duties or employment therein or therefore shall hereafter be exclusive of any other civil action or proceeding by reason of the same subject matter against such physician whose act or omission gave rise to such action or proceeding. "

"(b) The Attorney General shall defend any civil action or proceeding brought in any court against any person referred to in subsection (a) of this section for any such injury.

"(c) Upon a certification by the Attorney General that any person described in subsection (a) was acting in the scope of such person's duties or employment at the time of the incident out of which the suit arose, any such civil action or proceeding commenced in a State court shall be removed without bond at any time before trial by the Attorney General to the district court of the United States of the district and division embracing the place wherein it is pending and the proceeding deemed a tort action brought against the United States under the provision of title 28."

## **LEAVE**

### **ANNUAL LEAVE:**

**GENERAL POLICY:** Authorization of leave is contingent upon successful completion of military requirements. These requirements include the timely submission of house officer evaluation forms to the

education office, completion of administrative requirements associated with clinical duties, mandatory immunizations, physical fitness testing, taking and passing the step three examinations and obtaining a medical license, and other requirements associated with the responsibilities of a military physician.

PGY-I: During the first year, a resident is authorized 14 days leave. A leave form can be obtained from the Intern Director or, for psychiatry residents, from the office of the Chief of Psychiatry at each institution. The Attending Physician of the Service to which the resident is assigned during the requested leave period must initial the form. Each military service has specific policies about additional authorization. The secretary or enlisted department administrator in each medical center's Department of Psychiatry processes the form for Psychiatry Residents. You must obtain a copy of the form before you go on leave and complete the appropriate boxes when you return from leave. **In all instances the site training director and the Program Director must be informed of leave or other absences.** Because of the clinical demands of the PGY-I year of training, you are most strongly encouraged to take one week of leave during the mid-year holiday period when clinical service demands are slower.

PGY-II to PGY-IV: During the second to fourth years, a resident is authorized 30 days of annual leave. Leaves should be planned well ahead of time, and must have the approval of the service chief for whom you will be working at the time of the leave. The leave forms should be processed 30 days in advance of planned leave. A limited number of residents will be allowed to be on leave at any one time, so it is wise to discuss leave plans with fellow residents to avoid conflicts. The Program Director must approve all leaves for residents, and this approval will be contingent upon the resident being in satisfactory status in his work and training program.

In general, leave will be restricted to no more than one week at a time. During one or two month rotations the amount of leave should be restricted to 3 days for each four week block of the rotation. (e.g., 3 days for a one month rotation – one week for two month rotation) Special accommodations are possible, but require sufficient advance notice and are not guaranteed. You are cautioned against obtaining non-refundable transportation tickets prior to receiving leave authorization at all levels.

## MATERNITY LEAVE

The following guidelines are based on military regulations concerning Maternity Leave, requirements of the ACGME, and recommendations of the American Medical Association. Residents who are planning to become parents are encouraged to discuss their plans with the Program Director so that they may make an early start on integrating this experience into their training program in a positive way. The maternity leave policy is described in more detail in the National Capital GME Consortium handbook.

### 1. Timing:

a. The inherent flexibility of the PGY-IV year accommodates a resident's individual training and parental needs. These guidelines will cover an uncomplicated pregnancy and parental leave occurring during the PGY-IV year.

b. The didactic and other training activities of PGY-I, II and III are essential. Pregnancy and parental leave during these years are a challenge, but every effort will be made to ensure a positive training outcome when pregnancy does occur. It is essential that the resident and training director begin planning early in the pregnancy so that adverse impact on the resident's training will be minimized.

### 2. Duration of Leave Allowed Before and After Delivery:

- a. Leave time taken prior to delivery, unless medically ordered, will count against regular leave/vacation time allowed by the program.
  - b. Following an uncomplicated delivery, D.O.D. policy allows for up to 50 days convalescent leave following discharge from the hospital. This time will not be counted against the leave/vacation time otherwise allowed for by the residency program.
3. Board Eligibility:
- a. A resident who uses all the time described above and fulfills all other requirements for graduation is still board eligible.
  - b. If the resident requires more time away from the program than described above, the additional amount of training needed to meet the residency requirements, if any, will be determined by the training director in coordination with the Policy Committee and in consultation with the ACGME.
4. Schedule Accommodations for the Pregnant Resident:
- a. Reduced hours are possible so long as a resident's training and service requirements are satisfied. Service chiefs are expected to facilitate scheduling of training and service requirements within a 9 hour day, including a 60 minute lunch hour.
  - b. Pregnant residents will not be scheduled for night call in the third trimester, and will not make up this duty. The call roster system allows the resident to defer call nights during the first and second trimester. Deferred night call will be made up over the months after return to full time duty, or may be taken in advance of the pregnancy.
6. Adoption and Paternity Leave Policy:
- a. No convalescent leave can be granted for an adopting parent. Adoption is not a medical condition.
  - b. Leave granted to residents adopting a child, and to natural fathers, will consist of up to two weeks regular leave time, or a PGY-IV resident may take up to 30 days regular leave.

#### RELIGIOUS LEAVE POLICY

The amount of time allowed off duty for religious leave will coincide with that required by the tenets of the trainee's religious obligations, including travel time. The actual administrative tool used to grant the time off can be any of the several provided by military service regulations (passes, compensatory time, leaves, etc.). The service chief responsible for the trainee at the time of leave may choose any of these, subject to the approval of the Site Training Director and the Department Chief. If the religious obligation requires the trainee to leave the local area, he/she is required to request ordinary leave.

**Board Eligibility:** A resident who misses three months from one training year because of religious obligations remains board eligible. If a resident loses more than three months time in one training year, the training director will determine any additional time needed for board eligibility.

**Schedule Accommodations:** It is the resident's responsibility to arrange coverage to provide for patient care during absences for religious observances.

## EMERGENCY LEAVE

Emergency leave is usually restricted to deaths or illness of family members or other unforeseen serious matters. The Attending Physician of the Service, to which the resident is assigned during the requested emergency leave period verbally approve the leave. The Program Director or Site Training Director signs the form authorizing the leave. In all instances the Program Director must be informed of the leave (this may be by voice mail or electronic mail in the event of evening or weekend departures). The secretary or enlisted department administrator in each medical center's Department of Psychiatry processes the form for Psychiatry Residents. When possible you must obtain a copy of the form before you go on leave and complete the appropriate boxes when you return from leave. When emergencies occur that prohibit following normal procedure, the resident or designated family member must contact the staff psychiatrist on call, who will notify necessary service chiefs and attending physicians on the next duty day. Residents are responsible for completing all leave paperwork upon return from an emergency leave where forms were not completed prior to departure.

**Essentials of Accredited Residencies in Graduate Medical Education - (Required by ACGME/RRC to be provided to all residents)**

I. The Education of Physicians

Medical education in the United States occurs in three major phases.

A. Undergraduate Medical Education

Undergraduate medical education is the first or “medical school” phase. The medical school curriculum provides instruction in the sciences that underlie medical practice and in the application of those sciences to health care. Students learn basic information gathering, decision-making, and patient-management skills in rotations through the various clinical services. Students are granted the MD or DO degree on the successful completion of the medical school curriculum and are eligible to undertake the next phase of medical education.

Accreditation of educational programs leading to the MD degree is the responsibility of the Liaison Committee on Medical Education (LCME). Accreditation of educational programs leading to the DO degree is the responsibility of the American Osteopathic Association.

B. Graduate Medical Education

Graduate medical education (GME), the second phase, prepares physicians for practice in a medical specialty. GME focuses on the development of clinical skills and professional competencies and on the acquisition of detailed factual knowledge in a medical specialty. This learning process prepares the physician for the independent practice of medicine in that specialty. The programs are based in hospitals or other health care institutions and, in most specialties, utilize both inpatient and ambulatory settings, reflecting the importance of care for adequate numbers of patients in the GME experience. GME programs, including Transitional Year programs, are usually called residency programs, and the physicians being educated in them, residents.

The single most important responsibility of any program of GME is to provide an organized educational program with guidance and supervision of the resident, facilitating the resident's professional and personal development while ensuring safe and appropriate care for patients. A resident takes on progressively greater responsibility throughout the course of a residency, consistent with individual growth in clinical experience, knowledge, and skill.

The education of resident physicians relies on an integration of didactic activity in a structured curriculum with diagnosis and management of patients under appropriate levels of supervision and scholarly activity aimed at developing and maintaining life-long learning skills. The quality of this experience is directly related to the quality of patient care, which is always the highest priority. Educational quality and patient care quality are interdependent and must be pursued in such a manner that they enhance one another. A proper balance must be maintained so that a program of GME does not rely on residents to meet service needs at the expense of educational objectives.

A resident is prepared to undertake independent medical practice within a chosen specialty on the satisfactory completion of a residency. Residents in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME) typically complete educational requirements for certification by a specialty board recognized by the American Board of Medical Specialties (ABMS).

The accreditation of GME programs is the responsibility of the ACGME, its associated Residency Review Committees (RRCs) for the various specialties, and the Transitional Year Review Committee (TYRC)(hereafter referred to as “review committees”). Further information on the ACGME and the review committees is provided below.

C. Continuing Medical Education

Continuing medical education (CME) is the third phase of medical education. This phase continues the specialty education begun in graduate training; it reflects the commitment to life-long learning inherent in the medical profession.

The Accreditation Council for Continuing Medical Education (ACCME) is responsible for accrediting the providers of CME.

## II. Accreditation of GME Programs

### A. Accreditation, Certification, Licensure

In the context of GME, accreditation is the process for determining whether an educational program is in substantial compliance with established educational standards as promulgated in the institutional and program requirements. Accreditation represents a professional judgment about the quality of an educational program. Decisions about accreditation are made by the review committees under the authority of the ACGME.

Certification is the process for determining whether an individual physician has met established requirements within a particular specialty. The standards for certification are determined by the appropriate member specialty board recognized by the ABMS.

Licensure is distinct from both accreditation and certification. Licensure is a process of government through which an individual physician is given permission to practice medicine within a particular licensing jurisdiction. Medical licenses are granted by the Board of Medical Examiners (or the equivalent) in each licensing jurisdiction (the 50 states, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands).

### B. Accreditation of Residency Programs

Accreditation of residency programs is a voluntary process. By participating in the process, residency programs undergo regular review. The review helps programs in their goals of attaining and maintaining educational excellence. The review also serves to inform the public, specialty boards, residents, and medical students whether specific residency programs are in substantial compliance with the standards that have been established for GME.

For a program to become accredited, the sponsoring institution must demonstrate a commitment to GME. The sponsoring institution must be in substantial compliance with the Institutional Requirements and must assume responsibility for the educational quality of its sponsored program(s). (Further information concerning a "sponsoring institution" is provided below.)

The Institutional Requirements, which have been established by the ACGME, apply to all institutions that seek to sponsor programs in GME. An assessment of whether institutions fulfill these requirements is made by the ACGME through its institutional review process and by the review committees through their program review process.

The program must demonstrate to its RRC that it is in substantial compliance with the Program Requirements for its particular discipline and that it is sponsored by an institution in substantial compliance with the Institutional Requirements. Materials used by the review committees in making this determination include the results of the most recent institutional review conducted by the ACGME.

The Program Requirements are developed by each review committee for programs in its specialty. The Program Requirements specify essential educational content, instructional activities, responsibilities for patient care and supervision, and the necessary facilities of accredited programs in a particular specialty. In developing and updating Program Requirements, a review committee obtains comments on the proposed documents from interested parties and agencies. The review committee then decides on the final proposal to be submitted to the ACGME. The ACGME has final authority for approving all Program Requirements.

Accreditation actions taken by the review committees are based on information submitted by program directors and on the reports of site visitors. Actions of the committees, under the authority of the ACGME, determine the accreditation status of residency programs.

The ACGME is responsible for adjudication of appeals of adverse decisions and has established policies and procedures for such appeals.

Current operating policies and procedures for review, accreditation, and appeal are contained in the ACGME *Manual of Policies and Procedures for Graduate Medical Education Review Committees*. The *Manual* is reviewed annually and is revised as appropriate. (A copy of the *Manual*, as well as copies of the Institutional Requirements and of the Program Requirements, may be obtained from the Office of the Executive Director, ACGME, 515 N State St, Suite 2000, Chicago, IL, 60610.)

Information about the accreditation status of a residency program may be obtained by contacting the executive director of the ACGME.

C. Structure of the ACGME and of the RRCs

1. The ACGME is a voluntary association formed by five member organizations. Its member organizations are national professional bodies, each of which has major interests in and involvement with residency education.

The five member organizations of the ACGME are as follows:

- American Board of Medical Specialties (ABMS)
- American Hospital Association (AHA)
- American Medical Association (AMA)
- Association of American Medical Colleges (AAMC)
- Council of Medical Specialty Societies (CMSS)

Each member organization selects four representatives to the ACGME. The ACGME appoints two public members.

The Resident Physician Section of the AMA, with the advice of other national organizations that represent residents, selects a resident representative to the ACGME.

The Chair of the RRC Council, an advisory body of the ACGME, represents that group on the ACGME.

The Secretary of the US Department of Health and Human Services designates a nonvoting representative of the federal government to the ACGME.

2. There is an RRC for each of the specialties in which certification is offered by a specialty board that is a member of the ABMS. Each RRC is sponsored by the AMA's Council on Medical Education, by the board that certifies physicians within that specialty, and in most cases, by the professional college or other professional association within the specialty.

The Transitional Year Review Committee, which accredits 1 year of GME consisting of rotations in multiple clinical disciplines, is appointed directly by the ACGME.

The established RRCs and their respective sponsors are listed in the chart above.

Residency Review Committee	Sponsoring Organizations
Allergy and Immunology	American Board of Allergy and Immunology (A Conjoint Board of the American Board of Internal Medicine and the American Board of Pediatrics) AMA Council on Medical Education
Anesthesiology	American Board of Anesthesiology AMA Council on Medical Education American Society of Anesthesiologists
Colon and Rectal Surgery	American Board of Colon and Rectal Surgery American College of Surgeons AMA Council on Medical Education
Dermatology	American Board of Dermatology AMA Council on Medical Education

Emergency Medicine	American Board of Emergency Medicine American College of Emergency Physicians AMA Council on Medical Education
Family Practice	American Academy of Family Physicians American Board of Family Practice AMA Council on Medical Education
Internal Medicine	American Board of Internal Medicine American College of Physicians AMA Council on Medical Education
Medical Genetics	American Board of Medical Genetics American College of Medical Genetics AMA Council on Medical Education
Neurological Surgery	American Board of Neurological Surgery American College of Surgeons AMA Council on Medical Education
Neurology	American Academy of Neurology American Board of Psychiatry and Neurology AMA Council on Medical Education
Nuclear Medicine	American Board of Nuclear Medicine AMA Council on Medical Education Society of Nuclear Medicine
Obstetrics-Gynecology	American Board of Obstetrics and Gynecology American College of Obstetricians and Gynecologists AMA Council on Medical Education
Ophthalmology	American Academy of Ophthalmology American Board of Ophthalmology AMA Council on Medical Education
Orthopaedic Surgery	American Academy of Orthopaedic Surgeons American Board of Orthopaedic Surgery AMA Council on Medical Education
Otolaryngology	American Board of Otolaryngology American College of Surgeons AMA Council on Medical Education Residency Review Committee Sponsoring Organizations
Pathology	American Board of Pathology AMA Council on Medical Education
Pediatrics	American Academy of Pediatrics American Board of Pediatrics AMA Council on Medical Education
Physical Medicine and Rehabilitation	American Academy of Physical Medicine and Rehabilitation American Board of Physical Medicine and Rehabilitation AMA Council on Medical Education
Plastic Surgery	American Board of Plastic Surgery American College of Surgeons AMA Council on Medical Education
Preventive Medicine	American Board of Preventive Medicine AMA Council on Medical Education
Psychiatry	American Board of Psychiatry and Neurology AMA Council on Medical Education American Psychiatric Association
Diagnostic Radiology	American Board of Radiology American College of Radiology AMA Council on Medical Education

Radiation Oncology	American Board of Radiology American College of Radiology AMA Council on Medical Education
Surgery	American Board of Surgery American College of Surgeons AMA Council on Medical Education
Thoracic Surgery	American Board of Thoracic Surgery American College of Surgeons AMA Council on Medical Education
Urology	American Board of Urology American College of Surgeons AMA Council on Medical Education

### III. A Glossary of Selected Terms Used in GME Accreditation

**Applicants:** Persons invited to come for an interview for a GME program.

**Consortium:** Two or more organizations or institutions that have come together to pursue common objectives (eg, GME). A consortium may serve as a "sponsoring institution" for GME programs if it is formally established as an ongoing institutional entity with a documented commitment to GME.

**Desirable:** A term, along with its companion "highly desirable," used to designate aspects of an educational program that are not mandatory but are considered to be very important. A program may be cited for failing to do something that is desirable or highly desirable.

**Essential:** (See "Must")

**Fellow:** A term used by some sponsoring institutions and in some specialties to designate participants in subspecialty GME programs. The *Graduate Medical Education Directory* and the ACGME use "resident" to designate all GME participants in ACGME-accredited programs.

**Institution:** An organization having the primary purpose of providing educational and/or health care services (eg, a university, a medical school, a hospital, a school of public health, a health department, a public health agency, an organized health care delivery system, a medical examiner's office, a consortium, an educational foundation).

**A. Major Participating Institution:** An institution to which residents rotate for a required experience and/or those that require explicit approval by the appropriate RRC prior to utilization. Major participating institutions are listed as part of an accredited program in the *Graduate Medical Education Directory*.

**B. Participating Institution:** An institution that provides specific learning experiences within a multi-institutional program of GME. Subsections of institutions, such as a department, clinic, or unit of a hospital, do not qualify as participating institutions.

**C. Sponsoring Institution:** The institution that assumes the ultimate responsibility for a program of GME.  
**Institutional Review:** The process undertaken by the ACGME to judge whether a sponsoring institution offering GME programs is in substantial compliance with the Institutional Requirements.

**Intern:** Historically, "intern" was used to designate individuals in the first year of GME; less commonly it designated individuals in the first year of any residency program. Since 1975 the *Graduate Medical Education Directory* and the ACGME have not used the term, instead referring to individuals in their first year of GME as residents.

**Internal Review:** The formal process conducted by a sponsoring institution to assess the educational effectiveness of its sponsored residency programs.

**Must (Shall, Essential):** Terms used to indicate that something is required, mandatory, or done without fail. These terms indicate absolute requirements.

**Program:** The unit of specialty education, comprising a series of graduated learning experiences in GME, designed to conform to the program requirements of a particular specialty.

**Resident:** A physician at any level of GME in a program accredited by the ACGME. Participants in accredited subspecialty programs are specifically included.

**Scholarly Activity:** Educational experiences that include active participation of the teaching staff in clinical discussions, rounds, and conferences in a manner that promotes a spirit of inquiry and scholarship; active participation in journal clubs, research conferences, regional or national professional and scientific societies, particularly through presentations at the organizations' meetings and publications in their journals; participation in research, particularly in projects that are funded following peer review and/or result in publications or presentations at regional and national scientific meetings; offering of guidance and technical support, eg, research design, statistical analysis, for residents involved in research; and provision of support for resident participation as appropriate in scholarly activities. May be defined in more detail in specific Program Requirements.

**Shall:** (See "Must")

**Should:** A term used to designate requirements that are so important that their absence must be justified. The accreditation status of a program or institution is at risk if it is not in compliance with a "should."

**Substantial Compliance:** The judgment made by experts, based on all available information, that a sponsoring institution or residency program meets accreditation standards.

**Suggested:** A term, along with its companion "strongly suggested", used to indicate that something is distinctly urged rather than required. An institution or a program will not be cited for failing to do something that is suggested or strongly suggested.

## **Accreditation Council for Graduate Medical Education PROGRAM REQUIREMENTS FOR RESIDENCY TRAINING IN PSYCHIATRY**

### **I. Introduction**

#### **A. Scope of Education**

An approved residency program in psychiatry must provide an educational experience designed to ensure that its graduates will possess sound clinical judgment, requisite skills, and a high order of knowledge about the diagnosis, treatment, and prevention of all psychiatric disorders as well as and the other common medical and neurological disorders that which relate to the practice of psychiatry. While residents cannot be expected to achieve the highest possible degree of expertise in all of the diagnostic and treatment procedures used in psychiatry in 4 years of training, those individuals who satisfactorily complete residency programs in psychiatry must be competent to render effective professional care to patients. Furthermore, they must have a keen awareness of their own strengths and limitations and of the necessity for continuing their own professional development. The didactic and clinical program must be of sufficient breadth and depth to provide residents with a thorough and well-balanced understanding of psychological, sociocultural, and neurobiological observations and theories and knowledge of major diagnostic and therapeutic procedures in the field of psychiatry. It must also provide the education and training necessary to understand the major psychiatric literature, to evaluate the reliability and validity of scientific studies, and to appropriately incorporate new knowledge into the practice of medicine. Programs are expected to operate in accordance with the AAMA Principles of Ethics with Special Annotations for Psychiatry@ and to ensure that the application and teaching of these principles are an integral part of the educational process.

## B. Duration and Scope of Education

### 1. Admission Requirements

Physicians may enter psychiatry programs at either the first-year or second-year postgraduate level. Physicians may enter programs at the second-year postgraduate level only after successful completion of one of the following:

- a. A broad-based clinical year of accredited training in the United States or Canada in programs in an Accreditation Council of Graduate Medical Education (ACGME)-accredited program in internal medicine, family practice, or pediatrics
- b. After a An ACGME-accredited transitional year program
- c. One year of an ACGME-accredited residency in a clinical specialty requiring comprehensive and continuous patient care
- d. For physicians entering at the PG-2 level, the PG-1 year may be credited toward the 48-month requirement

### 2. Length of the Program

- a. A complete psychiatry residency is 48 months. Twelve of those months may be spent in an ACGME-approved child and adolescent psychiatry residency. Accreditation by the ACGME is required for all years of the training program. Programs may not permit residents to use vacation time or other benefit time to advance the date of graduation from training. Although residency is best completed on a full-time basis, part-time training at no less than half time is permissible to accommodate residents with personal commitments (eg, child care).
- b. Any program that alters the length of training beyond these minimum requirements must present a clear educational rationale consonant with the Program Requirements and objectives for residency training. The program director must obtain the approval of the sponsoring institution and the Residency Review Committee (RRC) prior to implementation and at each subsequent review of the program.
- c. Prior to entry into the program, each resident must be notified in writing of the required length of training for which the program is accredited. The required length of training for a particular resident may not be changed without mutual agreement during his/her program, unless there is a break in his/her training or the resident requires remedial training.
- d. Programs should meet all of the Program Requirements of Residency Training in Psychiatry. Under rare and unusual circumstances, programs of either 1 year=s or 2 years= duration may be approved, even though they do not meet all of the above requirements for psychiatry. Such 1- or 2- year programs will be approved only if they provide some highly specialized educational and/or research programs. Also, such programs will be approved only if they ensure that residents will complete the didactic and clinical requirements outlined in the Program Requirements.

### 3. Program Format by Year of Training

#### a. First year of training

A psychiatric first postgraduate year must include at least 4 months in internal medicine, family practice, and/or pediatrics. This training must be in a clinical setting that provides comprehensive and continuous patient care.

- 1) Neurology rotations may not be used to fulfill this 4-month requirement.
- 2) One month, but no more, of this requirement can be fulfilled by an emergency medicine or intensive care rotation, as long as the experience is predominantly with medical evaluation and treatment as opposed to surgical procedures.
- 3) For residents transferring into a program, there must be documentation in the training record that they have met this requirement in either current or prior training.
- 43) A psychiatric first postgraduate year should not include more than 6 months in psychiatry and must not include more than 8 months in psychiatry.
- 4) A minimum of 2 months of neurology, or its full-time equivalent on a part-time basis, is required prior to completion of training. It is highly desirable that this experience occur during a psychiatric first postgraduate year, and it may include a maximum of 1 month of supervised inpatient or outpatient child neurology.

- 5) It is highly desirable that tThe program director of the Department of Psychiatry must maintain contact with residents during the first postgraduate year while they are on services other than psychiatry.
- b. The second through fourth years of training
 

Although some of the training described below may be offered in the first postgraduate year, all must be completed prior to graduation from the program.

  - 1) The program must have an explicitly described educational curriculum covering the broad spectrum of clinical psychiatry as outlined in V.B.1.a-o.
  - 2) The formal didactic instruction must include regularly scheduled lectures, teaching rounds, seminars, clinical conferences, and required reading assignments covering the topics identified in Section V.
  - 3) There must be an educationally sound balance among time spent in direct patient care, clinical and didactic teaching, and supervision. Formal educational activity shall have high priority in the allotment of the resident's time and energies. Service needs and clinical responsibilities must not prevent the resident from obtaining the requisite didactic educational activities and formal instruction.
  - 4) Planned Educational Experiences. Each program must offer its residents planned and sufficient educational experiences. These educational experiences should include presentations based on a defined curriculum, journal review, administrative seminars and research methods. They may include but are not limited to problem-based learning, laboratories, and computer-based instruction, as well as joint conferences cosponsored with other disciplines. The program should ensure that residents are relieved of nonemergent clinical duties to attend these planned educational experiences. Although release from some off-service rotations may not be possible, the program should require that each resident participate in at least 70% of the planned psychiatry educational experiences offered (excluding vacations). Attendance must be monitored and documented.

## **II. Institutional Organization**

### **A. Sponsoring Organization**

1. Programs should be conducted under the sponsorship of an institution that meets the Institutional Requirements that apply to residency programs in all specialties, as outlined in the *Essentials of Accredited Residencies*.
2. The administration of the sponsoring institution(s) should be understanding of and sympathetic to the attainment of educational goals and should evidence its willingness and ability to support these goals philosophically and financially. The latter includes a commitment by the institution and by the program that embraces appropriate compensation for faculty and residents, adequate offices and educational facilities, and support services, and opportunities for research.
3. It is important that each affiliated institution offer demonstrate significant commitment educational opportunities to the overall program. The reasons educational rationale for including each institution within the program must be stated. The number and distribution of participating training sites must not preclude satisfactory participation by residents in teaching and training didactic exercises. Geographic proximity will be one factor in evaluating program cohesion, continuity, and Acritical mass@. Affiliated training sites will be evaluated on the basis of whether they contribute to a well-integrated educational program with respect to both didactic and clinical experiences.

### **B. Selection and Appointment of Residents**

1. The program director is responsible for maintaining a process for selecting resident physicians who are personally and professionally suited for training in psychiatry. It is highly desirable that each program have a residency selection committee to advise the program director.

2. The program should must document the procedures used to select residents. Application records should must contain complete information from medical schools and graduate medical education programs. A documented procedure should must be in place for evaluating the credentials, clinical training experiences, past performance, and professional integrity of residents transferring from one program to another, including from an adult a general psychiatry to a child and adolescent psychiatry program. This procedure must include solicitation and documentation of relevant information from the training directors of the previous programs participated in by the transferring resident. This documentation must specify all clinical and didactic experiences for which the resident has been given credit. Those residents selected at the second postgraduate year or above must have satisfied the training objectives cited above for reaching that level of training.
3. The residency program director must accept only those applicants whose qualifications for residency include sufficient command of English to facilitate accurate, unimpeded communication with patients and teachers.
4. A transferring resident's educational program must be sufficiently individualized so that he/she will have met all the educational and clinical experiences of the program, as accredited, prior to graduation.
5. The RRC will determine the size of the program's permanent resident complement by approving a range based on the program's clinical and academic resources.
6. To promote an educationally sound, intellectually stimulating atmosphere and effective graded responsibility, programs must maintain a critical mass of at least three residents at each level of training. Programs that fall below this prescribed critical mass will be reviewed, and if this deficiency is not corrected, they will be subject to negative action, except when the number of PG-4 residents is below critical mass owing to residents entering child and adolescent psychiatry training.
7. Programs in which the number of residents exceeds the resources of patient population, faculty, or facilities for adequate training will be found deficient on the basis of size.
8. Any permanent change in the number of approved positions requires prior approval by the RRC.1[1]\* Prior approval is not required for temporary changes in resident numbers owing to makeup or remedial time for currently enrolled residents or to fill vacancies. Approval of permanent increases above the approved range of residents will require documentation that didactic and clinical training, including supervision, will not be compromised.

### **III. Faculty Qualifications and Responsibilities**

The program director leadership and the teaching staff are responsible for the general administration of the program, including those activities related to the recruitment, selection, instruction, supervision, counseling, evaluation, and advancement of residents and the maintenance of records related to program accreditation.

#### **A. Chair of Psychiatry**

The chair of psychiatry must be a physician and must either be certified by the American Board of Psychiatry and Neurology or judged by the Residency Review Committee to possess equivalent qualifications.

#### **AB. Program Director**

There must be a single program director responsible for the program. Each residency program must be under the direction of an experienced, fully trained, and qualified psychiatrist whose major responsibility is to maintain an excellent educational program. The residency program director must possess the necessary administrative, teaching, and clinical skills and experience to conduct the program. Continuity of leadership over a period of years is important to the stability of a residency program. Frequent changes in leadership or long periods of temporary leadership usually have a negative effect on an educational program and may adversely affect the accreditation status of the program. The program director must

1. be licensed to practice medicine in the state where the institution that sponsors the program is located. (Certain federal programs are exempted.)
2. be either certified by the American Board of Psychiatry and Neurology or judged by the Residency Review Committee to possess equivalent qualifications.

3. have an appointment in good standing to the medical staff of an institution participating in the program.
4. devote at least one-half of his/her time to the administration and operation of the educational program, including didactic, supervisory, and clinical teaching activities. Programs with multiple institutions, many residents, and/or a large clinical population will require additional time.

**BC. Responsibilities of the Program Director**

1. The program director must have appropriate authority to oversee and to organize the activities of the educational program. The responsibilities of this position should include but not be limited to the following:
  - a. Resident appointments and assignments in accordance with institutional and departmental policies and procedures
  - b. Supervision, direction, and administration of the educational activities
  - c. Coordination of training in each geographically separate institution
  - d. Selection and supervision of the teaching staff and other program personnel at each institution participating in the program.
  - e. Supervision of residents through explicit written descriptions of supervisory lines of responsibility for the care of patients. Such guidelines must be communicated to all members of the program staff.
  - f. Regular evaluation of residents' knowledge, skills, and overall performance, including the development of professional attitudes consistent with being a physician.
  - g. Provision of a written final evaluation for each resident who completes the program, as specified in Sections VI.A.7 and VI.A.8.
  - h. Preparation of a written statement outlining the educational goals of the program with respect to knowledge, skills, and other attributes of residents at each level of training and for each major rotation or other program assignment. This statement must be distributed to applicants, residents, and members of the teaching staff. It should be readily available for review.
  - i. Provision of written information to applicants and residents regarding financial compensation, liability coverage, and the policies regarding vacations, sick leave, parental leave, and other special leaves.
  - j. Implementation of fair procedures as established by the sponsoring institution regarding academic discipline and resident complaints or grievances.
  - k. Monitoring resident stress, including mental physical or emotional conditions inhibiting performance or learning and drug- or alcohol-related dysfunction. Program directors and teaching staff should be sensitive to the need for timely provision of confidential counseling and psychological support services to residents. Training situations that consistently produce undesirable stress on residents must be evaluated and modified.
  - l. Maintenance of a permanent record of evaluation for each resident that is accessible to the resident and other authorized personnel. These will be made available on review of program.
  - m. Preparation of an accurate statistical and narrative description of the program as requested by the RRC for Psychiatry.
  - n. Written notification to the Executive Director of the RRC within 60 days of any major change in the program that may significantly alter the educational experience for the residents, including
    - 1) changes in leadership of the department or the program;
    - 2) changes in administrative structure, such as an alteration in the hierarchical status of the program/department within the institution; and
    - 3) changes in the resident complement that would bring the number of residents below the required critical mass of three residents per year for 2 consecutive years.
    2. The program director must obtain prior approval for the following changes in the program in order for the RRC to determine if an adequate educational environment exists to support these changes:
      - a. The addition of any participating institution to which residents rotate for 6 months full-time equivalent (FTE) or longer
      - b. The addition or deletion of any rotation of six months FTE or longer
      - c. Any increase change in the approved number of resident positions in the program

d. Any change in the total length of the program.

On review of such proposals or important changes in a program, the RRC may determine that a site visit is necessary.**C. Education Policy Committee**

The director of the residency program should have an educational policy committee composed of members of the psychiatry program teaching staff that includes representation from the residents as well as a member of the teaching staff from each ACGME-approved subspecialty residency that may be affiliated with the psychiatry residency. There should be a written description of the committee, including its responsibility to the sponsoring department or institution and to the program director. This committee should participate actively in

1. planning, developing, implementing, and evaluating all significant features of the residency program, including the selection of residents (unless there is a separate residency selection committee);
2. determining curriculum goals and objectives; and
3. evaluating both the teaching staff and the residents.

#### **D. Number and Qualifications of the Faculty**

All members of the teaching staff must demonstrate a strong interest in the education of residents, sound clinical and teaching abilities, support of the goals and objectives of the program, commitment to their own continuing medical education, and participation in scholarly activities.

1. There must be a sufficient number of teaching staff to instruct and supervise adequately all the residents in the program. Members of the teaching staff must be able to devote sufficient time to meet their supervisory and teaching responsibilities. The residency must be staffed by a sufficiently wide variety and appropriate number of capable psychiatrists and other mental health professionals with documented qualifications to achieve the goals and objectives of the training program.
2. The faculty psychiatrists should be certified by the American Board of Psychiatry and Neurology or have equivalent qualifications in psychiatry satisfactory to the RRC.
3. A written record of the educational responsibilities of all staff and faculty members (whether full-time or part-time) who participate directly in the education of residents is essential. That record should include the qualifications and experience of each faculty member and the nature, as well as the frequency, duration, and site, of the teaching activity.
4. There must be evidence of scholarly activity among the faculty psychiatrists. Scholarly activity is defined as professional activities that serve to enhance the profession or professional knowledge. While not all members of a faculty need be investigators, scholarly activities should be present on a continuous basis. There should also be evidence of participation in a spectrum of academic and professional activities within the institution as well as within local and national associations. Such evidence should include
  - a. documentation of teaching excellence;
  - b. participation in clinical and/or basic research;
  - c. involvement in relevant medical scientific organizations and their meetings; and
  - d. publications in refereed journals, monographs, and books.
5. The faculty must participate regularly and systematically in the training program and be readily available for consultation whenever a resident is faced with a major therapeutic or diagnostic problem.
6. The faculty psychiatrists should actively participate in the planning, organization, and presentation of conferences as well as in clinical teaching and supervision.
7. A member of the teaching staff of each participating institution must be designated to assume responsibility for the day-to-day activities of the program at that institution, with overall coordination by the program director.
8. The teaching staff must be organized and have regular documented meetings to review program goals and objectives as well as program effectiveness in achieving them. At least one resident representative should participate in these reviews.
9. The teaching staff should periodically evaluate the utilization of the resources available to the program, the contribution of each institution participating in the program, the financial and

administrative support of the program, the volume and variety of patients available to the program for educational purposes, the performance of members of the teaching staff, and the quality of supervision of residents.

**E. Other Program Personnel**

Programs must be provided with the additional professional, technical, and clerical personnel needed to support the administration and educational conduct of the program.

**IV. Program Facilities and Resources**

**A. Clinical Facilities and Resources**

1. All programs must have adequate patient populations for each mode of required training and, minimally, must include organized clinical services in inpatient, outpatient, emergency, consultation/liaison, and child and adolescent psychiatry.
2. Training programs must have available to them adequate inpatient and outpatient facilities, clinics, agencies and other suitable clinical placements where the residents can meet the educational objectives of the program. The program should specify the facilities in which the goals and objectives are to be implemented.
3. All residents must have available offices adequate in size and decor to allow them to interview patients and accomplish their duties in a professional manner. The facility also must provide adequate and specifically designated areas in which residents can perform basic physical examination and other necessary diagnostic procedures and treatment interventions.

**B. Other Educational Resources**

1. The administration of the facility where the program is located must provide ample space and equipment for educational activities. There must be adequate space and equipment specifically designated for seminars, lectures, and other teaching exercises.
2. The program must have available audiovisual equipment and teaching material such as films, audio cassettes, and videotapes, as well as the capability to record and play back educational videotapes.
3. Residents must have ready access to a major medical library, either at the institution where the residents are located or through arrangement with convenient nearby institutions. Library services should include the electronic retrieval of information from medical databases.
4. There must be access to an on-site library or and/or to an electronic collection of appropriate texts and journals in each institution participating in a residency program. On-site libraries and/or collections of texts and journals must be readily available during nights and weekends.  
This library should provide
  - a. a substantial number of current basic textbooks in psychiatry, neurology and general medicine;
  - b. a number of the major journals in psychiatry, neurology, and medicine sufficient for an excellent educational program;
  - c. the capability to obtain textbooks and journals on loan from major medical libraries; and
  - d. capability to perform MEDLINE or other medical information searches (or ready access to a library that has this capacity); and
  - e. access to the Internet.
5. Each clinical service must have a mechanism that ensures that charts are appropriately maintained and readily accessible for regular review for supervisory and educational purposes. Randomly selected charts will be reviewed at the time of survey.

**V. The Educational Program**

The director and teaching staff of a program must prepare and comply with written educational goals for the program. All educational components of a residency program should be related to program goals. The

program design and/or structure must be approved by the RRC for Psychiatry as part of the regular review process.

**A. Objectives of Training**

1. First Year

The training obtained during the first postgraduate year should provide residents with medical skills most relevant to psychiatric practice. These include being able to

- a. undertake the initial clinical and laboratory studies of patients presenting with a broad range of common medical and surgical disorders to perform a complete initial history and physical examination, including appropriate diagnostic studies;
- b. diagnose common medical and surgical disorders and to formulate appropriate initial treatment plans;
- c. provide limited, but appropriate, continuous care of patients with medical illnesses and to make appropriate referrals;
- d. be especially conversant with medical disorders displaying symptoms likely to be regarded as psychiatric, and with psychiatric disorders displaying symptoms likely to be regarded as medical;
- e. be especially cognizant of the nature of the interactions between psychiatric treatments and medical and surgical treatments; and
- f. relate to patients and their families, as well as other members of the health care team with compassion, respect and professional integrity.

2. Second Through Fourth Years

The program must provide a well-planned, high-quality curriculum that includes specific, assessable objectives for program components as well as criteria for graduation. These must be in writing and provided to each resident and faculty member. Residents must be taught to conceptualize all illnesses in terms of biological, psychological, and sociocultural factors that determine normal and disordered abnormal behavior. They must be educated to gather and organize data, integrate these data within a comprehensive formulation of the problem to support a well-reasoned differential diagnosis, formulate a treatment plan, and implement treatment and follow-up care as required. The program must provide residents with sufficient opportunities to develop professionalism, knowledge, clinical skills, sensitivity to cultural diversity, and professional principles.

a. The didactic curriculum should include

- 1) critical appraisals of the major theories and viewpoints in psychiatry, together with a thorough grounding in the generally accepted clinical facts;
- 2) presentation of the biological, psychological, sociocultural, economic, ethnic, gender, religious/spiritual, sexual orientation, and family factors that significantly influence physical and psychological development in infancy, childhood, adolescence, and adulthood throughout the life cycle;
- 3) presentation of the etiologies, prevalence, diagnosis, treatment, and prevention of all major of the psychiatric conditions disorders in the current standard diagnostic statistical manual to include , including the biological, psychological, sociocultural, and iatrogenic factors that affect the long-term course and treatment of psychiatric illness disorders/conditions;
- 4) comprehension of the diagnosis and treatment of neurologic disorders commonly encountered in psychiatric patients practice such as neoplasms, dementia, headaches, head trauma traumatic brain injury, infectious diseases, movement disorders, multiple sclerosis, Parkinson's disease, seizure disorders, stroke, intractable pain, and other related disorders;
- 5) the use, reliability, and validity of the generally accepted diagnostic techniques, including physical examination of the patient, laboratory testing, imaging, neurophysiologic and neuropsychological testing, and psychological testing;

- 6) the financing and regulation of psychiatric practice, including information about the structure of governmental public and private organizations that influence mental health care;
  - 7) medical ethics as applied to psychiatric practice;
  - 8) the history of psychiatry and its relationship to the evolution of modern medicine;
  - 9) the legal aspects of psychiatric practice;
  - 10) when and how to refer; and
  - 11) research methods in the clinical and behavioral sciences related to psychiatry.
- b. Clinical training should provide sufficient experiences in
- 1) the elements of clinical diagnosis with all age groups (of both sexes, to include some ethnic minorities), such as interviewing; clear and accurate history taking; physical, neurological, and mental status examination; and complete and systematic recording of findings;
  - 2) relating history and clinical findings to the relevant biological, psychological, and social behavioral, and sociocultural issues associated with etiology and treatment;
  - 3) formulating a differential diagnosis and treatment plan for all psychiatric disorders conditions in the current standard nomenclature, taking into consideration all relevant data;
  - 4) the major types of therapy, including short- and long-term individual psychotherapy, psychodynamic psychotherapy, family/couples therapy, group therapy, cognitive and behavior therapy, crisis intervention, drug and alcohol detoxification, and pharmacological regimens, including concurrent use of medications and psychotherapy; and other somatic therapies and drug and alcohol detoxification.
  - 5) Electroconvulsive therapy, a somatic therapy that is viewed as so important that its absence must be justified (Examples of other somatic therapies include biofeedback and phototherapy.);
  - 5)6) providing continuous care for a variety of patients from different age groups, seen regularly and frequently for an extended time, in a variety of treatment modalities;
  - 6)7) psychiatric consultation in a variety of medical, and surgical and community settings;
  - 7)8) providing care and treatment for the chronically mentally ill with appropriate psychopharmacologic, psychotherapeutic, and social rehabilitative interventions;
  - 8)9) psychiatric administration, especially leadership of interdisciplinary teams, including supervised experience in utilization review, quality assurance and performance improvement;
  - 9)10) providing psychiatric care to patients who are receiving treatment from nonmedical therapists and coordinating such treatment;
  - 10)11) knowledge of the indications for and limitations of the more common psychological and neuropsychological tests;
  - 11)12) critically appraising the professional and scientific literature; and
  - 12)13) Teaching Ability to teach psychiatry to medical students, residents, and others in the health professions.

## B. Curriculum

### 1. Clinical Experience

Carefully supervised clinical care of patients is the core of an adequate program. The clinical services must be so organized that residents have major responsibility for the care of a significant proportion of all patients assigned to them and have sufficient and ongoing high-quality supervision. The number of patients for which residents have primary responsibility at any one time must be small adequate enough to permit them to provide each patient with appropriate treatment and to have sufficient time for other aspects of their educational program. At the same time, the total number must be large enough to provide an adequate depth and variety of clinical experiences. The amount and type of patient care responsibility a resident assumes must increase as the resident advances in training. Each resident must have major responsibility for the diagnosis and treatment of a reasonable number and adequate

variety of patients with both acute and chronic illnesses representing the major psychotic and nonpsychotic categories of psychiatric illness diagnoses/conditions. Adequate experience in the diagnosis and management of the medical and neurological disorders encountered in psychiatric practice also must be ensured. Each resident must have supervised experience in the evaluation and treatment of patients of both sexes, of various ages from childhood to old age of different ages throughout the life cycle and from a variety of ethnic, racial, social sociocultural, and economic backgrounds. It is desirable that residents have didactic learning and supervised experiences in the delivery of psychiatric services in the public sector (such as community mental health centers and public hospitals and agencies) and in managed care health systems. The clinical experiences are to be designed to develop the requisite skills as outlined in Section V.A.2.b., above. Specific clinical experiences must include the following:

a. Neurology: Two months of SSupervised clinical experience in the diagnosis and treatment of patients with neurological patients disorders/conditions. This 2-month experience (or its equivalent if done on a part-time basis) may occur in either an inpatient, outpatient, and/or consultation/liaison basis setting. A maximum of one month of child neurology may be used toward the 2-month requirement. The 2-month training experience must provide opportunities to conduct initial evaluations, to participate in the subsequent diagnostic process, and to follow patients during the treatment and/or evolution of their neurological illness disorders/conditions. The training in neurology should have sufficient didactic and clinical experience for residents to develop expertise in the diagnosis of those neurological disorders/conditions that might reasonably be expected to be encountered in psychiatric practice and that must be considered in the differential diagnosis of psychiatric disorders/conditions.

b. Inpatient: Significant responsibility for the assessment, diagnosis, and treatment of an appropriate number and variety of general adult psychiatric inpatients for a period of not less than 9 months, but no more than 18 months (or its full-time equivalent if done on a part-time basis), in four years of training. In general, it is highly desirable that the minimum general adult inpatient experience be 12 months, although it is recognized that in some settings other training opportunities might lead to the absolute minimum of 9 months. Inpatient rotations on specialized clinical services such as substance abuse, geriatrics, research units, day and/or partial hospitalization, and child and adolescent psychiatry will not be included in assessing the required minimum nine-month inpatient experiences for residency training, unless the rotation on such specialized units is comparable in breadth, depth, and experience to training on general inpatient units. Those rotations not fulfilling the above requirement will be included in assessing the maximum allowable eighteen month inpatient experience. The experience must provide residents with sufficient opportunities to develop competence in the intensive biopsychosocial assessment and management of patients with acute mental disorders/conditions. It is recognized that the setting in which this care occurs may vary according to the health care delivery system. Rotations on specialized clinical services such as addiction psychiatry, adolescent psychiatry, forensic psychiatry, geriatric psychiatry research units, and day and/or partial hospitalization may not totally substitute for the general psychiatric inpatient experience. These may be included to meet the required minimum experiences, with adequate documentation to demonstrate that the experience on such specialized units is with acutely ill patients and is comparable in breadth, depth, and experience to training on general inpatient psychiatry units. Up to 3 months of rotations on specialized clinical services as noted above may be applied to the minimum 9-month requirement. However, no portion of this experience may be counted to meet the timed requirements in addiction, child and adolescent, or geriatric psychiatry. Experience in any special unit used to provide inpatient psychiatry must be under the direction and supervision of a psychiatrist.

c. Outpatient: An organized, continuous, supervised clinical experience in the assessment, diagnosis, and treatment of outpatients of at least 1 year (or its full-time equivalent if done on a part-time basis) that emphasizes a developmental and biopsychosocial approach to outpatient treatment. At least 90% of this experience must be with adult patients 18 years of age or older. A minimum of 20% of the overall experience (clinical time and patient volume) must be continuous and followed for a duration of at least 1 year.

This The outpatient requirement must include experience with a wide variety of disorders, patients, and treatment modalities, with experience in both brief and long-term care of patients, using individual psychotherapy (including psychodynamic, cognitive, behavioral, supportive, brief), and biological treatments and psycho social rehabilitation approaches to outpatient treatment. Long-term psychotherapy experience must include a sufficient number of patients, seen at least weekly for at least 1 year, under supervision. Other long-term treatment experiences should include patients with differing disorders and chronicity and some patients who are chronically mentally ill. No portion of this experience may be counted to meet the timed requirements (eg, child and adolescent psychiatry).

d. Child and Adolescent Psychiatry: An organized clinical experience under the supervision of qualified child and adolescent psychiatrists in the evaluation, diagnosis, and treatment of children, adolescents, and their

families. Such experiences should be no less than 2 months full-time equivalent and involve a sufficient number and variety of patients, by both age and psychopathology, treated with a variety of interventional modalities. Residents should have experiences in determining the developmental status and needs for intervention with the children of some of their adult patients, and in consulting with these patients regarding the referral of their children for psychiatric services. Residents must have patient care responsibility under the supervision of qualified child and adolescent psychiatrists who are certified by the American Board of Psychiatry or its equivalent. This 2-month experience may be provided in a variety of settings (eg, outpatient). While adolescent inpatient units may be used to satisfy a portion of this requirement, rotations to student health services may not.

e. Consultation/Liaison: Supervised psychiatric consultation/liaison responsibility of for a minimum of 2 months full-time equivalent, involving adult patients on other medical and surgical services. While On-call experiences may be a part of this training, such experiences alone will not be sufficient to constitute adequate training in consultation/liaison psychiatry. Up to 1 month of pediatric consultation/liaison psychiatry may be credited toward the 2-month requirement.

f. Emergency Psychiatry: Supervised responsibility on an organized, 24-hour psychiatric emergency service that is responsible for evaluation, crisis management, and triage of psychiatric patients. Instruction and experience should be provided in learning crisis intervention techniques, including the evaluation and management of suicidal patients. A psychiatric emergency service that is a part of, or interfaces with, other medical emergency services is desirable because of the opportunities for collaboration and educational exchange with colleagues in other specialties. There must be organized instruction and supervised clinical opportunities available to residents experience in emergency psychiatry that leads to the development of knowledge and skills in the emergency evaluation, crisis management, and triage of patients. This should include the assessment and management of patients who are a danger to themselves or others, the evaluation and reduction of risk to care givers, and knowledge of relevant issues in forensic psychiatry. There should be sufficient continued contact with patients to enable the resident to evaluate the effectiveness of clinical interventions. While on-call experiences may be a part of this training, such experiences alone will not be sufficient to constitute adequate training in emergency psychiatry. A portion of this experience may occur in ambulatory urgent care settings but must be separate and distinct from the 12 months of training designated for the outpatient requirement.

g. Community Psychiatry: Supervised responsibility in community-based mental health activities. This should include consultation with at least one community agency. for the care of persistently chronically ill patients in the public sector, (eg, community mental health centers and public hospitals and agencies, or other community-based settings). Experiential settings may include residential treatment centers, community mental health agencies, vocational rehabilitation centers, and senior citizen agencies. Opportunities should exist to consult with, learn about, and use community resources and services in planning patient care and to work collaboratively with case managers, crisis teams, and other mental health professionals.

h. Geriatric Psychiatry: One-month FTE Supervised clinical management of geriatric patients with a variety of psychiatric disorders, including familiarity with long-term care in a variety of settings.

i. Addiction Psychiatry: One-month FTE Supervised evaluation and clinical management of patients with alcoholism and drug abuse substance use disorders, including detoxification and long-term management in inpatient and/or outpatient settings, and familiarity with rehabilitation and self-help groups.

j. Forensic Psychiatry: Supervised eExperience under the supervision of a psychiatrist in evaluation of patients with forensic problems.

k. Supervised clinical experience in the evaluation and treatment of couples, families, and groups.

l. Techniques for evaluation and management of danger (of the patient to self and others) should be taught in every aspect of patient care.

ml. Psychological Testing: Supervised experience with the more common psychological test procedures, including neuropsychological assessment, in a sufficient number of cases to give the resident an understanding of the clinical usefulness of these procedures and of the correlation of psychological test findings with clinical data. Under the supervision and guidance of a qualified clinical supervisor psychologist, residents should have experience with the interpretation of the psychological tests most commonly used, and some of this experience should be with their own patients.

n. Supervised experience in utilization review and total quality management.

om. Supervised, active collaboration with psychologists, psychiatric nurses, social workers, and other professional and paraprofessional mental health personnel in the treatment of patients.

-----  
2. Didactic Components

The didactic and clinical curriculum must be of sufficient breadth and depth to provide residents with a thorough, well-balanced presentation of the generally accepted theories, schools of thought, and major diagnostic and therapeutic procedures in the field of psychiatry.

a. The curriculum must include a significant number of interdisciplinary clinical conferences and didactic seminars for residents in which psychiatric faculty members collaborate with neurologists, internists, and colleagues from other medical specialties and mental health disciplines.

b. Didactic instruction must be systematically organized, thoughtfully integrated, based on sound educational principles, and include prepared lectures, seminars, and assigned readings that are carried out on a regularly scheduled basis. In a progressive fashion, it should expose residents to topics appropriate to their level of training as outlined in Section V.A.2. Staff meetings, clinical case conferences, journal clubs, and lectures by visitors visiting professors are desirable adjuncts, but must not be used as substitutes for an organized didactic curriculum.

c. The curriculum must include adequate and systematic instruction in neurobiology; psychopharmacology, and other clinical sciences relevant to psychiatry, child and adult development; major psychological theories, including learning theory and psycho dynamic theory and appropriate material from the sociocultural and behavioral sciences such as sociology and anthropology. The curriculum should address development, psychopathology, and topics relevant to treatment modalities employed with patients with severe psychiatric illness including the chronically mentally ill disorders/conditions.

d. The residency program should provide its residents with instruction about American culture and subcultures, particularly those found in the patient community associated with the training program. This instruction should include such issues as sex gender, race, ethnicity, socioeconomic status, religion/spirituality, and sexual orientation. Many physicians may not be sufficiently familiar with attitudes, values, and social norms prevalent among various groups of contemporary Americans. Therefore, the curriculum should contain enough instruction about these issues to enable residents to render competent care to patients from various cultural and ethnic backgrounds. This instruction must be especially comprehensive in those programs with residents whose cultural backgrounds are significantly different from those of their patients. Understanding cultural diversity is an essential characteristic of good clinical care. The program must devote sufficient didactic training to residents whose cultural backgrounds are different from those of their patients and provide a suitable educational program for them.

e. Didactic exercises should must include resident presentation and discussion of clinical case material at conferences attended by faculty and fellow residents. This training should involve experiences in formulating and discussing the theoretical and practical issues involved in the diagnosis and management of the cases presented. integrative case formulation that includes neurobiological, phenomenological, psychological, and sociocultural issues involved in the diagnosis and management of cases presented.

3. Supervision: Clinical training must include adequate, regularly scheduled, individual supervision. Each resident must have at least 2 hours of individual supervision weekly, in addition to teaching conferences and rounds except when on non-psychiatric rotations, in the PG-2 through PG-4 years of training. Residents must be provided with prompt, reliable systems for communication and interaction with supervisory physicians.

4. Clinical Records

Clinical records must reflect the residents' ability to

a. record an adequate history and perform mental status, physical, and neurological examinations;

b. organize a comprehensive differential diagnosis and discussion of relevant psychological and sociocultural issues;

c. proceed with appropriate laboratory and other diagnostic procedures;

d. develop and implement an appropriate treatment plan accompanied followed by regular and relevant progress notes; and

e. prepare an adequate discharge summary and plan.

C. Resident Policies

1. The program should not allow on-call schedules and activities outside the residency to that interfere with education, clinical performance, or clinical patient care responsibilities. The program should ensure

a. one day out of 7 free of program duties;

b. on average, on-call duty no more than every third night fourth night while on psychiatric services; and

- c. adequate backup if patient care needs create resident fatigue sufficient to jeopardize patient care or resident welfare during or following on-call periods.
2. Each resident must be given a copy of the Essentials of Accredited Residencies at the beginning of training.
3. Readily available procedures for assisting the resident to obtain appropriate help for significant personal or professional problems should be in place.

#### **D. Other Required Components**

##### **1. Scholarly Activity of the Residents and Faculty**

Graduate medical education must take place in an environment of inquiry and scholarship in which residents participate in the development of new knowledge, learn to evaluate research findings, and develop habits of inquiry as a continuing professional responsibility. The following components of a scholarly environment should be present:

- a. The program must promote an atmosphere of scholarly inquiry, including the provision of access to ongoing research activity in psychiatry. Residents must be taught the design and interpretation of research studies, including the responsible use of informed consent, research methodology, and interpretation of data. The program must teach expertise in the critical assessment of new therapies and developments that are described in the literature. Residents must be advised and supervised by faculty members qualified in the conduct of research. Programs must have a plan to foster the development of skills for residents who are interested in conducting psychiatric research. This plan should include opportunities for conducting research under the supervision of a mentor and training in the principles and methods of research.
- b. Active participation of the teaching staff in clinical discussions, rounds, and conferences in a manner that promotes a spirit of inquiry and scholarship. Scholarship implies an in-depth understanding of basic mechanisms of normal and abnormal states and the application of current knowledge to practice.
- c. Participation in journal clubs and research conferences.
- d. Active participation in regional or national professional and scientific societies, particularly through presentations at the organizations' meetings and publications in their journals.
- e. Participation in research, particularly in projects that are funded following peer review and/or result in publications or presentations at regional and national scientific meetings.
- f. Offering of guidance and technical support (eg, research design, statistical analysis) for residents involved in research.
- g. Provision of support for resident participation in scholarly activities.

##### **2. Progressive Responsibility**

Under supervision, resident clinical experience in patient management should demonstrate graduated and progressive responsibility.

##### **3. Teaching Opportunities**

An important part of the education of the resident is the development of teaching skills. Residents should must be instructed in appropriate methods of teaching and have ample opportunity to teach students in the health professions.

##### **4. Electives**

All programs should provide residents an opportunity to pursue individually chosen electives.

##### **5. Resident Logs Record of Clinical Experience**

There must be a record maintained of specific cases treated by residents, in a manner that does not identify patients but that illustrates each resident's clinical experience in the program. This record must demonstrate that each resident has met the educational requirements of the program with regard to variety of patients, diagnoses, and treatment modalities. In the case of transferring residents, the records should include the experiences in the prior as well as the current program. This record should must be reviewed periodically with the program director or a designee and be made available to the surveyor of the program.

#### **VI. Internal Evaluation**

The educational effectiveness of a program must be evaluated in a systematic manner. In particular, the quality of the curriculum and the extent to which the educational goals have been met by residents must be assessed. Written evaluations by residents should be utilized in this process.

#### **A. Evaluation of Residents**

All programs should state specifically and as clearly as possible the objectives and competencies required for successful completion of the program. These objectives and criteria should be made available to residency applicants.

1. Regular, systematic, documented evaluation of the knowledge, skills, and professional growth of each resident, using appropriate criteria and procedures, must be maintained, including complete records of evaluations containing explicit statements on the resident's progress toward meeting educational objectives and his/her major strengths and weaknesses. Each evaluation should be communicated to the resident in an ongoing and timely manner.
2. The program must provide opportunity for and document regularly scheduled meetings between the resident and the program director or designated faculty members. These meetings should be of sufficient frequency, length and depth to ensure that the residents are continually aware of the quality of their progress toward attainment of professional expertise goals and objectives. These evaluation sessions should be held at least semiannually and preferably more frequently. The program should give residents opportunities to assess the program and the faculty in a manner that ensures resident confidentiality. Provision should be made for remediation in cases of unsatisfactory performance.
3. The program must formally examine the cognitive knowledge of each resident at least annually in the PG-2 through PG-4 years, and conduct an organized examination of clinical skills at least twice during the 4 years of training. In a timely manner, the program must develop specific remedial plans for residents who do not perform satisfactorily. Residents must not advance to the next year of training, or graduate from the program, unless the outcome from the remedial plan results in the attainment of educational and clinical goals established for the program.
4. Residents should be advanced to positions of higher responsibility only on the basis of evidence of their satisfactory progressive scholarship and professional, educational, and clinical growth.5. A written set of due-process procedures must be in place for resolving problems that occur when a resident's performance fails to meet required standards. These procedures must conform to those policies and procedures adopted by the sponsoring institution for the provision of due process to all residents training in sponsored programs, and must include the criteria for any adverse action, such as placing a resident on probation, or for terminating a resident whose performance is unsatisfactory. The procedures should be fair to the residents, to patients under their care, and to the training program. A copy should be provided to the residents at the beginning of training.
6. Upon any resident's departure from a program (including by graduation), the program director must prepare a letter describing the nature and length of the rotations for which the resident has been given credit. If a resident departs the program without receiving full credit for all educational experiences, the reasons for withholding credit must be specified in the letter. The resident must be given the letter, and a copy must be retained in the resident's permanent file.
7. When a resident leaves the program (including by graduation), the program director will affirm in the training record that there is no documented evidence of unethical or unprofessional behavior, nor any serious question regarding clinical competence. Where there is such evidence, it will be comprehensively recorded, along with the responses of the trainee. The evaluation should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. This final evaluation should be part of the resident's permanent record maintained by the institution.
8. For residents transferring to child and adolescent psychiatry, it is essential that the program director document the nature and length of the rotations for which the resident has been given credit and include a listing of any remaining requirements needed to successfully complete the general psychiatry program. The resident must be informed that eligibility for certification by the American Board of Psychiatry and Neurology is not possible unless all general psychiatry program requirements are met, even if the resident completes the requirements for training in child and adolescent psychiatry. A copy of this notification must be provided to the resident and a copy included in the resident's permanent file.

## **B. Evaluation of Resident Competencies**

The residency program must demonstrate that it has an effective plan for assessing resident performance throughout the program and for utilizing assessment results to improve resident performance.

1. This plan should include use of dependable measures to assess residents' competence in
  - a. patient care
  - b. medical knowledge

- c. practice-based learning and improvement
- d. interpersonal and communication skills
- e. professionalism
- f. systems-based practice
- 2. The program must demonstrate that residents have achieved competency in at least the following forms of therapy:
  - a. Brief therapy
  - b. Cognitive-behavioral therapy
  - c. Combined psychotherapy and psychopharmacology
  - d. Psychodynamic therapy
  - e. Supportive therapy
- 3. A mechanism must be in place for providing regular and timely performance feedback to residents which utilizes assessment results to achieve progressive improvements in the performance of residents in each competency area.
- 4. Programs that do not have a set of measures in place must develop a plan for improving their evaluations or demonstrate progress in implementing such a plan.
- 5. The program must provide documented evidence to demonstrate that the proficiency/competence of each resident is assessed using techniques that may include supervisory reports, videotapes, oral examinations, case reports, patient care observations, or other methods.

### **C. Program Evaluation**

- 1. Performance and outcome assessment results should be used to evaluate the educational effectiveness of the residency program.
- 12. Participation in and performance of graduates on examinations for certification by the American Board of Psychiatry and Neurology may be one measure of the quality of a program used by the Residency Review Committee in its evaluation of each program. Therefore, it is highly desirable that programs use such information as one measure of their quality control.
- 23. Programs must demonstrate that they have an ongoing mechanism to evaluate the effectiveness of their didactic and clinical teaching.

## **VII. Inquiries Concerning Accreditation and Certification**

- A.** All inquiries concerning the accreditation of psychiatry residencies should be addressed to Executive Director, Residency Review Committee for Psychiatry, 515 N State St / Ste 2000, Chicago, IL 60610.
- B.** All inquiries as to whether a physician is qualified to be admitted for examination for certification in psychiatry should be addressed to Executive Vice President, American Board of Psychiatry and Neurology, 500 Lake Cook Rd / Ste 335, Deerfield, IL 60015.

File: h\programreq\psypr.799.lt.wpd  
 12191999\_h:\ltrs\lds\psypr.799.lt.wpd

-----